

De Montfort University

**An exploration of factors affecting the use of  
community pharmacy services by South  
Asians in Leicester**

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## ABSTRACT

Understanding the philosophy of a different culture and integrating this understanding into the provision of pharmaceutical care is challenging and complex. This thesis argues the importance for community pharmacists to acknowledge that culture, religion, family and community dynamics can impact on patients' health, health seeking behaviour and medicines adherence. The perceptions of members of the South Asian<sup>1</sup> population, general practitioners, and community pharmacists about how these factors are viewed in relation to community pharmacy services were explored in this study. It was conducted in Leicester City, which has a South Asian minority ethnic population of more than 25%. Participants' views of the role of extended community pharmacy services in the wider government agenda were explored. South Asians attitudes to healthcare, self care and the management of minor ailments were discussed.

A qualitative methodology approach was adopted, which used constructivist and interpretive principles. Data collection for the study was conducted in two phases. In Phase 1, one to one semi-structured interviews were conducted separately with six local GPs and five community pharmacists from both 'white' (European) and South Asian backgrounds. In Phase 2, six gender specific focus groups were convened comprising of fifty five participants in total from the Sikh, Moslem and Hindu communities. Bi-lingual community workers were used in this study which allowed a more 'sensitive' exploration of the sociological aspects of health seeking behaviour and the impact of 'cultural' influences on medicines adherence.

The need for 'cultural competence' of community pharmacists is discussed as one of the major contributions to the evidence base for pharmacy practice. Such initiatives would require pharmacists to acquire more effective consultation skills in the first instance. South Asians expressed views that community pharmacists need to be more knowledgeable, responsive and flexible in their professional practice by assessing their pharmaceutical needs and being aware of particular cultural sensitivities when planning their services in line with the new pharmaceutical contract. More specifically, South Asian participants illustrated the need for community pharmacists and their staff to be more 'culturally knowledgeable' about the communities in which they practice. It is argued that the provision of a more culturally sensitive and pro-active service is needed to develop a better patient-practitioner professional relationship that promotes trust. South Asians illustrated how certain behavioural, religious and cultural beliefs impact on medicines adherence, such as compliance issues whilst on holiday to their homeland, the impact of religious pilgrimage

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<sup>1</sup> The term South Asian refers to people whose origins can be traced to the Indian sub-continent comprising of Pakistan, India, Sri Lanka and Bangladesh

and fasts. Many South Asian participants had limited understanding about 'generic' medicines and considered these to be 'inferior' or 'less effective' than 'branded' medication. Participants' views of 'sharing' of medicines and medicines waste were also illustrated. Factors such as 'stress', 'fate' and 'karma' and their impact on health of the participants were discussed. Many of these factors could not be solely attributable to a South Asian 'culture'. However, the findings illustrate a need for a Medicines Use Review (MUR) service to include more 'targeted' exploration of medicines adherence and medicines optimisation for this population. The findings also highlighted why South Asians rarely consult the community pharmacist about sensitive or stigmatised issues such as depression, and how some conditions and symptoms were perceived to have negative impact on the 'social acceptance' of South Asian individuals within their own communities. South Asians suggested that community pharmacists needed to be more pro-active and 'responsive' to their pharmaceutical needs and respect confidentiality through use of private consultation areas for routine counselling, health promotion and medicines information.

All participants endorsed a need for more 'professional' recognition of the pharmacist not only as an autonomous health care professional, but as one integral to providing NHS services relating to medicines and public health. The findings illustrated a lack of professional collaboration between community pharmacists and GPs, confounded by community pharmacists being 'subordinate' to GPs and portraying more of a 'shopkeeper' image. South Asians were well informed about the lack of shared medical records and relied heavily on a doctor's definitive 'diagnosis' for somatic symptoms related common ailments.

South Asians pro-actively engaged with 'community action' based approaches in health education and health promotion, and an opportunity for community pharmacists to become more involved with social initiatives was inferred from the findings. Candid and animated discussions explored their understanding of exercise as part of weight management and their interpretation of effects of the use of herbal products, alternative practitioners and the importance of collaboration with religious and community leaders in promoting medicines adherence. Participants desired alternative communication methods other than leaflets (translated or otherwise), including the use of audio-visual means and use of media. Communication difficulties were still prevalent, and trained interpreters were rarely used.

By embracing some of these challenges, community pharmacists could enhance the value of their services and provide a more meaningful, 'culturally' competent and responsive services based on the needs of their local populations and nurture a better trusting and professional relationship with their service users and healthcare colleagues.

## **DEDICATION**

**This thesis is dedicated to my wonderful  
family**

**To my husband Bharat, and my daughters  
Shrina and Ria**

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This thesis was possible due to the fact that I had an amazing group of people who guided me through this enjoyable, memorable and at times, very challenging journey. They are my research 'family' across three institutions De Montfort University (DMU), University Hospital of Leicester NHS Trust (UHL) and University of Leicester (UoL).

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## GLOSSARY

**Access:** the extent to which people are able to receive the information, services or care they need.

**APHO:** The Association of Public Health Observatories (APHO) represents a network of 12 public health observatories (PHOs) working across the five nations of England, Scotland, Wales, Northern Ireland and the Republic of Ireland. The APHO produces information, data and intelligence on people's health and health care for practitioners, policy makers and the wider community. EMPHO is one of the PHOs (see below).

**BME:** The Black and Minority Ethnic (BME) population. BME include communities who identify themselves as Black and communities who are ethnic minorities in this country (including new migrant communities like people from Poland for example, refugee and asylum seeker communities, etc). Although the initial ethnic minority communities may have come from colonised countries in South Asia, the Caribbean, Africa and China, the minority ethnic communities currently living in Britain are infinitely more diverse.

**Complementary and Alternative medicine (CAM):** The term alternative medicine was originally introduced to refer to whole medical systems that did not fit with conventional medicine. These systems have completely different philosophies together with different ideas on causes of disease, methods of diagnosis and approaches to treatment and were seen as a replacement for conventional healthcare. Complementary medicine (or therapies) is used to refer to those methods which can be used alongside or to 'complement' conventional medicine, but the distinction between alternative and complementary medicine is not absolute and may depend on the context. Many people now use the term complementary and alternative medicine (CAM) to include both approaches. The term integrated (or integrative) medicine has been introduced more recently and is used to refer to systems in which conventional healthcare and complementary therapies are integrated within a practice or an institution. Examples can include naturopathy, chiropractic medicine, herbalism, traditional Chinese medicine, Ayurveda (India), Unani (Pakistan), meditation, yoga, biofeedback, hypnosis, homeopathy, acupuncture, and nutritional-based therapies, in addition to a range of other practices.

**CHAI:** The Commission for Health, Audit and Inspection was established by the Health and Social Care (Community Health and Standards) Act 2003 and is now known as the Healthcare Commission.

**Clinical governance:** a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

**DH:** Department of Health, UK

**DN:** **Davinder Nagra** is a research assistant and a community health worker who assisted in the Phase 2 interviews and Phase 1 and 2 analysis for this PhD study.

**EMPHO:** The **East Midlands Public Health Observatory** is one of nine regional PHOs funded by the Department of Health to strengthen the availability and use of health information at a local level. EMPHO covers the East Midlands Government Office Region.

**English NHS body:** a primary care trust, strategic health authority or NHS trust, all or most of whose hospitals, establishments and facilities are situated in England, or an NHS foundation trust or special health authority performing functions only or mainly in respect of England.

**Governance:** a mechanism to provide accountability for the way an organisation manages itself.

**Hakim:** A hakim is several things in Arabic: a ruler or judge as well as a wise person or physician. It is also a title given to someone practicing alternative medicine mainly in Arabic countries and Pakistan.

**Healthcare Commission:** established in April 2004 as the independent body encompassing the work of the Commission for Health Improvement (CHI). The Healthcare Commission takes on functions transferred from the national NHS value for money work of the Audit Commission and the independent healthcare work of the National Care Standards Commission (NCSC). It inspects health care provision in accordance with national standards and other service priorities and will report directly to Parliament on the state of health care in England and Wales.

**Health care organisation:** English NHS bodies, cross-border SHAs and other organisations and individuals, including the independent and voluntary sectors, which provide or commission health care for individual patients and the public.

**Health care professional:** a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

**Health care:** services provided for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.

**Health promotion:** includes the provision of information on healthier lifestyles for patients, and how to make the best use of health services, with the intention of enabling people to make rational health choices and of ensuring awareness of the factors determining the health of the community.

**Health Protection Agency (HPA):** The Health Protection Agency's role is to provide an integrated approach to protecting UK public health through the provision of support and advice to the NHS, local authorities, emergency services, other Arms Length Bodies, the Department of Health and the Devolved Administrations. The Agency was established as a special health authority (SpHA) in 2003

**Joseph Rowntree Foundation:** an endowed charity that funds a large, UK-wide research and development programme. It seeks to understand the root causes of social problems, to identify ways of overcoming them, and to show how social needs can be met in practice.

**Mary Seacole Research Centre (MSRC):** The MSRC was set up as a collaborative initiative between De Montfort University and The Royal College of Nursing. The Centre works closely with staff in all departments of the Faculty of Health and Life Sciences and others across the University with an interest in issues of race and ethnicity in health and social care. Particular research concerns include care planning in a multi-ethnic NHS, employment opportunities and career development of black and minority ethnic staff, and specific ethnic health care needs. Collaborative working with practitioners in health and welfare service agencies and community groups is seen as a priority, to ensure active dissemination and implementation of research findings.

**NHS Ethnic health unit (EHU):** set up in 1994 to work with ethnic minority community organisations to foster confidence in the NHS among black and minority ethnic people.

**National Prescribing Centre (NPC):** The National Prescribing Centre is a health service organisation, formed in April 1996 by the Department of Health. The centre facilitates developments in policy and providing relevant and valid support on prescribing and medicines management. It promotes and supports the delivery of high quality, cost-effective prescribing and medicines management across the NHS, to help improve patient care and service delivery.

**National Service Frameworks (NSFs)** set national standards and identify key interventions for a defined service or care group; put in place strategies to support implementation; and establish ways to ensure progress within an agreed time-scale.

**National Institute of Health and Clinical Excellence (NICE):** a special health authority for England and Wales. Its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current “best practice”. The guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques, and procedures) and the clinical management of specific conditions.

**Patient:** those in receipt of health care provided by or for an English NHS body or cross-border SHA.

**Patient Group Direction (PGD):** Patient Group Directions (PGDs) are documents which make it legal for medicines to be given to groups of patients without individual prescriptions having to be written for each patient. They can also be used to empower staff other than doctors (for example paramedics, pharmacists and nurses) to legally give the medicine in question.

**PILs:** Patient information leaflets

**Primary care:** first-contact health services directly accessible to the public

**Primary care trust (PCT):** a local health organisation responsible for managing local health services. PCTs work with local authorities and other agencies that provide health and social care locally to make sure the community's needs are being met.

**Project Dil:** Project Dil is a health promotion programme in Leicester City NHS looking mostly into primary and secondary prevention, by increasing understanding of Coronary Heart Disease (CHD) in the South Asian community through education and interventions in GP practices.

**Public health:** Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients.

**Quality assurance:** a systematic process of verifying that a product or service being developed is meeting specified requirements.

**Research governance framework:** defines the broad principles of good research governance and is key to ensuring that health and social care research is conducted to high scientific and ethical standards and applies to all research undertaken within the remit of the Secretary of State for Health.

**Risk management:** covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

**Runnymede Trust:** Runnymede is an independent race equality 'think tank'. The trust generates intelligence for a multi-ethnic Britain through research, network building, leading debate, and policy engagement

**Service user:** an individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.

**South Asian (SA):** The term South Asian refers to people from the Indian sub-continent comprising of Pakistan, India, Sri Lanka and Bengal

**Strategic Health Authority (SHA) :** responsible for developing plans for improving health services in its local area; making sure local health services are of a high quality and are performing well; increasing the capacity of local health services so they can provide more services; and making sure national priorities are integrated into local health service plans.

**Vahid (or Vaid):** A title given to someone practicing alternative medicine mainly in India.



# Chapter 1

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## **Introduction and background**

## CHAPTER 1. INTRODUCTION AND BACKGROUND

*'No culture can live, if it attempts to be exclusive'*

(Mahatma Gandhi, 1869-1948)

There is evidence that the National Health Service (NHS) in England and Wales including primary care services such as community pharmacy, has not catered well to our multi-ethnic population. Epidemiological evidence indicates that people from British Minority Ethnic (BME) South Asian backgrounds experience a much higher burden of ill health from major illnesses such as diabetes, cardiovascular disease and ischaemic heart disease as compared with the 'white' population (Smaje, 1995; Nazroo, 1997). Health inequalities are a major concern of health policy in England, with strong emphasis being placed on the wider social and structural factors that cause ill health (Acheson, 1998). For pharmacists and healthcare professionals to have an appreciable role in providing an equitable and culturally competent service for the South Asian population, it was important to have an understanding of how ethnic differences in health and health beliefs may be different to that of a 'white' population as well as being aware if (or how) cultural factors contribute to the health and well being of this particular population. This thesis presents the perceptions of fifty five South Asian members of the public (from the Hindu, Sikh and Muslim faiths), five community pharmacists (from White and South Asian backgrounds) and six general practitioners (from White and South Asian backgrounds) in relation to the question whether community pharmacy services are meeting the pharmaceutical needs of the South Asian population, and explores the reasons behind their perceptions, including cultural influences and barriers.

This PhD study stemmed from a major study undertaken in Birmingham in 1994 (Jesson et al, 1994b, 1995). Jesson et al concluded that pharmacy services were not utilised effectively by the South Asian ethnic population because of both communication problems and how the pharmacist's role is perceived by this particular population. There is little research in this population group since the study by Jesson et al (1994b). Research findings, if any, have not been widely published, and do not provide a firm evidence base to underpin major policies. The healthcare requirements of the minority needed to be investigated further to see whether cultural attitudes and beliefs still impact on their use of community pharmacy services and if they had changed over time.

## **Box 1. Research aims and intended outcomes**

### **RESEARCH AIMS**

This thesis explores the following areas:

- Perceptions of the current pharmacy services by members of the local South Asian ethnic population and local GPs
- GPs and pharmacists' knowledge of cultural sensitivities (if any) relating to the use of medicines by the local South Asian ethnic population.
- Barriers and incentives for the 'new' extended community pharmacy services from local GPs, community pharmacies and members of the local South Asian ethnic minority population

### **INTENDED OUTCOMES**

- identify cultural beliefs that influence a GP consultation process and the role of the community pharmacist
- identify patient education and patient health information needs of members of the South Asian ethnic minorities
- highlight methods to improve communication process between pharmacists , GPs and members of this community
- ascertain barriers and/or opportunities (if any) for future community service initiatives in improving the health of this population, particularly relating to the management of minor ailments and medicines adherence

The term 'South Asian' in this thesis refers to those whose original background is from the Indian sub – continent i.e. from the countries India, Pakistan and Bangladesh. For convenience and ease of reference to the 2001 census, the author of this study has used the same broadly-based definitions and categories as those adopted by the census itself. In this respect, the South Asian population of the UK, as defined by the national census, comprises those of Indian, Pakistani or Bangladesh descent. The author also uses the broad term 'white' to refer to the indigenous population (Office of National Statistics, 2003). According to the 2001 census, 92% of the UK population is White, which included significant non-British White minorities such as Irish people. The Black and minority ethnic (BME) population was comprised of 4% Asian or Asian British, 2% Black or Black British and 1.5% of mixed race. The Census also indicated an increase in the percentage of minority ethnic members of the population by approximately 50% in the decade spanning 1991-2001. (Office of National Statistics, 2003). After the World Wars, Britain actively recruited labour from the Commonwealth countries to aid the reconstruction effort. Since then there had

been a steady influx of South Asians in to the UK. (Walker et al, 1980). The UK has become more multi-ethnic. Latest figures indicate that BME groups now account for 73% of the UK's total population growth, due to differences in fertility rates and some inward migration. (Parliamentary office and Postnote, 2007)

This PhD study was conducted in Leicester City in the East Midlands. Local census data demonstrates that a significant proportion of the population of the city comes from a South Asian background. The city was chosen as it was the practice base for the author, and also provided a 'natural' research setting to explore key areas for the study objectives in the South Asian minority ethnic population. The largest minority ethnic group in the East Midlands region is Indian (2.9 per cent of the population, compared with 2.1 per cent of the population of England as a whole). Leicester has the highest proportion of Indians in the country (25.7%). East Midlands has the second highest proportion of Hindus in England and Wales (1.6%). In Leicester, 14.7% of people are Hindu, 11% Muslim and 4.2 % Sikh (Leicestershire County council report (2005) taken from 2001 census data). The study deals with participants in only the inner city setting, including GPs and community pharmacists who are actively practicing within the Belgrave and Highfields area of Leicester City. The findings are particular to these areas, and the findings are not intended to be a general study of the views of the UK's ethnic minority population. Pertinent census statistics for Leicester City are illustrated further in this chapter.

The thesis was conceived during radical changes in the way NHS services were to be delivered, including ambitious plans for community pharmacy services. Key policy reviews and reports relating to the health inequalities debate, NHS reforms and reforms in pharmacy services and in particular the relevance of ethnicity and 'culture' on community pharmacy services have been explored in this thesis. Major government policies state a wider role for community pharmacists to deliver 'reformed' services to improve the delivery of pharmacy services to improve health outcomes for people with long term conditions, as well as a wider public health role in addressing the healthcare needs of local populations as part of reducing health inequalities (DH, 2000b; 2003a; DH, 2005a; DH, 2008b). Government reforms in the National Health Service (NHS) also call for major changes in how health services are envisaged through multi-disciplinary collaboration between professionals in health and social care settings both nationally and locally (DH, 2000c). The modernisation of the NHS has also highlighted the Government's intention to improve the public's access to health services, information on preventing ill health and support for self-care (DH, 2004c; DH, 2005f). Community pharmacies are in a strong

position to contribute to this agenda with around 12,000 dedicated premises in the UK creating an informal network of 'drop in' access points for health care services, medicines and advice on health and well-being. In Leicestershire, there are over 200 community pharmacies, of which there are currently 75 in Leicester City (2010 figures).

The need for pharmacists to be able to effectively work with patients of different cultures is based on professional and ethical standards required by the Royal Pharmaceutical Society's code of ethics (RPSGB, 2005 and 2007b). The primary responsibility of the pharmacist is to improve the quality of life and health outcomes of patients by improving their drug therapy. However, this thesis will argue that if pharmacists do not understand their own culture or that of their patients, then they cannot understand how culture can impact pharmaceutical care and adherence to treatment. Patient views regarding health care, medications, and quality of life are influenced in many ways by their culture, whether they are from a majority 'white' population or from a black minority ethnic (BME) background. It will also be argued that without having the knowledge and skills needed to communicate and work with patients of various cultures, the proper implementation of pharmaceutical care may be impaired. This PhD study set out to explore from the viewpoints of South Asian service users, whether community pharmacists were meeting their health and 'pharmaceutical' needs, particularly in light of new health service reforms. These reforms and highlight that services to minority ethnic communities need to improve, with health promotion and communication being part of this agenda (DH, 2003b). Community pharmacists have been engaged in such activities to varying degrees for many years. Today they are envisaged as a 'significant' player in public health, although so far this has largely been at the micro-level in activities such as health promotion rather than on wider public health issues. The new 'vision' of the pharmacy contract and the extended roles of the pharmacist, in meeting the needs of a diverse population appears to offer potential for more flexible and sensitive approaches to care, particularly as a member of a multi-disciplinary group. The understanding of different cultures and 'collaboration' is a particularly new concept to community pharmacy. The current emphasis on the community pharmacy being 'accessible' by way of their locations in community settings and on the high street has prompted further research in this field. For pharmacists and other health care professionals to have an appreciable role in providing an equitable service for the South Asian population, it was important to have an understanding of how these

issues may be different to that of a 'white' population as well as being aware of various risk factors for different diseases states in this particular population.

One of the pharmacists' major roles includes assessing patients' symptoms and deciding whether they could be 'major' (which warrants a referral to a doctor) or 'minor'. Where appropriate, pharmacists can recommend the purchase of 'over the counter' medicines to treat their symptoms. The literature shows that many patients who go to the GP as their first port of call for 'minor' symptoms can be given a prescription for medicines that could be directly purchased under the supervision of the pharmacist without the need for consulting a GP. One of the 'new' schemes envisaged in the NHS White papers for pharmacy (DH, 2000b and DH, 2003a) included the promotion of the pharmacist to be the first port of call for the management of minor ailments. Such a scheme would allow the patient to consult a community pharmacist for advice and if necessary, be given an over the counter (OTC) remedy without the need to pay for this. It was perceived that this would allow GPs time to deal with more serious cases. A study in Sefton, Merseyside explored the transfer of the management of minor ailments from general medical practice to community pharmacy (Whittington et al; 2001). The study concluded that 38% of minor ailment consultations were transferred from GPs to community pharmacists, significantly reducing the GP minor ailment workload in the GP practice. This initiative could be potentially significant in promoting the health advisory role of the pharmacist to communities where a significant majority of the population cannot afford to pay for medication normally available for purchase through community pharmacies. A particular aspect of this PhD study explores the management of minor ailments by the South Asian population group. Pharmacy research on the management of minor ailments and self care in this population is sparse. In this thesis, participants' views about the use of the community pharmacist as a first port of call for the management of 'minor' ailments were sought. Their views of whether such a service would be beneficial in Leicester City were discussed, along with their perceptions of community pharmacists providing other 'extended' services envisaged in the pharmacy White Paper (DH,2000b) at a time when radical shifts in healthcare provision were being considered within the local Primary Care Trust in Leicester City. The scope of this study was intended to highlight barriers (cultural or otherwise) and/or opportunities for the use of community pharmacy services by this population.

At the time when this PhD study was conducted, there appeared to be a wealth of written information available to members of the South Asian population, in different languages covering various disease states. There was also access to services available at local and national level (e.g. British Diabetic Association, local Health

Promotion Centres) but none dealing specifically about the use of conventional medicines. Local “in house” patient information leaflets (PILs) in some South Asian languages had been produced for specific drugs and methods of drug administration by various local hospital pharmacy departments. It must be emphasized that it is not only communication needs that are important for pharmacists working with the South Asian ethnic minorities. An overall understanding of the cultural issues surrounding the use of both conventional and traditional Asian medicines on medicines use as well as the impact of other cultural sensitivities on their health beliefs was also needed. For example, the Fast of Ramadan may just be one of many other important factors that can have a wider impact on health in this population. Some research has been undertaken looking at the medicine and health information needs of the ethnic minority populations, particularly in the South Asian community. To date, the evidence suggests that communication between members of the public and health professionals can and should be improved. The literature highlighted that the NHS needs to provide accessible interpreting services for all health care personnel. This can also have implications for the innovative service delivery strategies suggested in the new NHS reforms, for example the telephone help line NHS Direct. All these aspects were also explored in this thesis.

There appeared to be a huge potential for further research in exploring how community pharmacists could contribute to addressing the health care needs in South Asian Minority ethnic populations, particularly to their use of community pharmacy services relating to medicines adherence and management of self limiting minor conditions (Alexander, 1999; Atkinson et al, 2001; Bissell et al, 2003b). In the UK, the code of ethics for pharmacists (RPSGB, 2007b) states that as part of their professional practice, pharmacists must show respect for others, and this includes recognising diversity and respect of cultural differences, values and beliefs of service users. The research reported in this thesis is based on the belief that there may be a need for a sensitive, professional and ‘culturally competent’ pharmacy service delivered to South Asian members of the public.

This PhD study is important and timely for several reasons. The research methodology in this study utilises a constructivist, pluralist and critical realism approach that adds further insight to the findings from traditional, more quantitative methodologies adopted in the literature. It was necessary to see if the recommendations made by Jesson et al (1994b) were still valid, and if a more in-depth qualitative enquiry could give a better insight to the findings of that study.

The literature showed that there is a clear lack of published, 'evidence based' research. Most pharmacy practice research is based on the 'biomedical model' as opposed to understanding the 'holistic' approaches to patient behaviour and the use of health care services underpinned by sociological, psychological and at times, cultural underpinnings. The challenge was to also explore research methodologies that could be suitable to further investigate issues about the initial beliefs of the investigator, the findings and recommendations emerging from the wider literature. The author's personal practice experiences also questions these influences to her practice as a community pharmacist. She firmly believes that that the pharmacists' role is *complementary and not subordinate* to that of a medically trained doctor, whether in hospital or in general practice. Community pharmacists have been historically trained to deliver a standardized UK based NHS contractual pharmacy service and minimal flexibility for a more 'holistic' approach to pharmaceutical healthcare which encompassed the sociological and psychological needs of patients, particularly for those from diverse backgrounds.

Having worked extensively in Leicester City, the author's observations of how South Asian service users interacted with her and her colleagues in a community pharmacy were intriguing. Over time, she noticed that South Asians' uptake and perception of the community pharmacist's 'expertise' as a health care professional was somewhat 'different' to her observations working in a pharmacy where there was a predominantly 'white' population. South Asians appeared to be more 'anxious' about their general health and well being, and in many cases were not able to communicate directly (or readily) about their health beliefs or symptoms. In many cases they declined advice about the management of their symptoms from a community pharmacist and preferred to consult the general practitioner (GP). Many returned with a prescription for medicine(s) that could have been initially suggested by the community pharmacist as an 'over the counter' purchase. They seemed more reassured when they had the same medication given to them by a doctor on a prescription. Even though the investigator could speak two South Asian languages, she was spending more time with South Asian service users to explain aspects of health prevention, and that there may not be any need for medication for certain 'minor' symptoms. However, an intervention from a GP seemed to be better 'accepted' by this population.

Between 1997 and 2000, the author worked at the Medicines Information Centre at the Leicester Royal Infirmary. She was involved in the trial of a patients' 'medicines helpline', a telephone service for members of the public about the use of medicines.



Many queries were received from people from a South Asian background whose first language was not English. As a bi-lingual pharmacist the investigator was asked to respond to queries from patients who preferred to speak in Gujarati. Queries ranged from advice on medicines and also for management of symptoms. The viability of a medicines helpline in different South Asian languages warranted further exploration, and this was one of the initial concepts for this study.

During this time the author also worked as a Primary Care Trust Prescribing Advisor in Leicester City. Her experiences of working as a practice advisor with GPs in Leicester was also challenging. South Asian GPs appeared to be more knowledgeable about the cultural habits of their South Asian population and conducted the consultations in South Asian languages. She noticed a lack of translated information leaflets pertinent to health and medicines. She was often invited to 'interpret' for 'white' GPs whilst she worked in their practices, as there were many times when there was nobody available in the practice who could speak a South Asian language.

Whilst the investigator commended the ambitious plans by the Government policies, her experiences led to question her observations and her own beliefs about the utilization of community pharmacy services by the local South Asian population. The author's initial appraisal of the major policy implications, the key research and her own beliefs prompted the following questions:

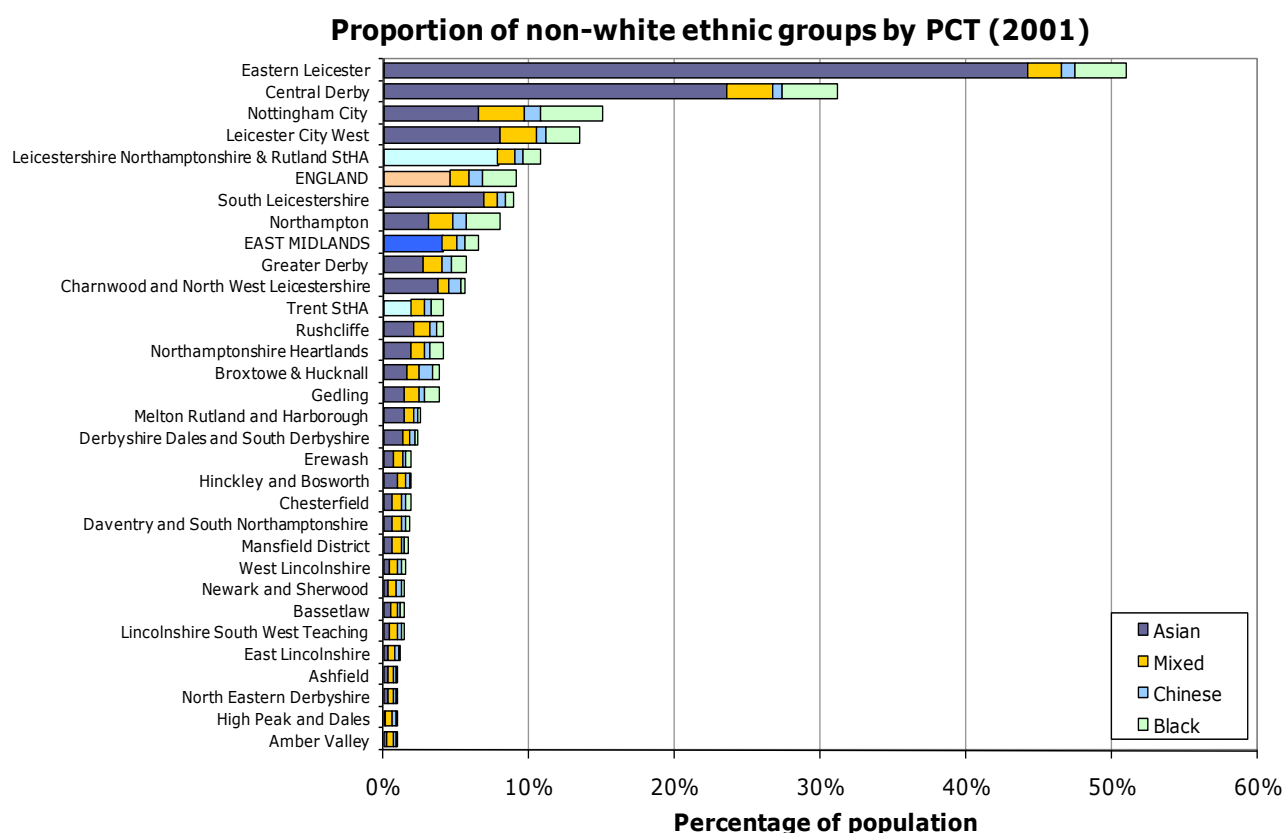
- What do South Asians think of community pharmacists and their role?
- Will they go to the pharmacist as a first port of call for minor ailments instead of the GP? In particular, will they accept health advice from a community pharmacist without being given medication? If not, why not? Will they accept the pharmacists' recommendations for the management of minor ailments? How would the GPs perceive the new minor ailments services being proposed?
- What do GPs think about the proposed new roles of community pharmacists?
- Are there any barriers that GPs and community pharmacists face in communicating with South Asians?
- Are there any cultural patterns influencing health seeking patterns could explain the perceived 'under use' of the community pharmacist as a health care advisor?
- Is there a natural 'assumption' that community pharmacists and general practitioners from a South Asian background in Leicester are knowledgeable about the local South Asian cultures and health beliefs of their communities?

- Do community pharmacists rely on their own experiences and beliefs to address any cultural issues raised by their South Asian service users?
- Is it assumed that South Asians members of the public consult pharmacists from the same ethnic background and get 'culturally appropriate' advice?
- Can it be assumed that just because South Asians migrated to Britain they would have integrated into the social 'norms' of living in a 'Western' culture and hence consult community pharmacists in a similar way to the general population? If it is different, why is it different?

### **The setting for the study**

Within East Midlands, the areas with the largest ethnic minority communities were Leicester City (36%), Oadby and Wigston (in Leicestershire County: 16%) and Nottingham (15%). The population of Leicester City, Leicestershire county and Rutland was managed by local Primary Care Groups (PCGs) which eventually became Primary Care Trusts (PCTs). Until 2003, the health and social care needs of the population of Leicester was managed by two PCTs. These were Eastern Leicester PCT and Leicester City West PCT. Leicestershire County and Rutland was split into primary care PCTs namely Hinckley and Bosworth; Oadby and Wigston; Melton, Rutland and Harborough; Charnwood and NW Leicestershire. The highest percentage of BME population in East Midlands reside in Eastern Leicester Primary Care Trust (51.0%), Central Derby (31.1%), Nottingham City (15.1%) and Leicester City West (13.5%) (see figure 1)

**Figure 1. The PCTs with the largest ethnic minority populations in East Midlands.** (East Midlands Public Health laboratory EMPHO (2005) reproduced with permission).



The table illustrates that Eastern Leicester Primary care Trust and Leicester City West Trust (combined) have a significant proportion of Asian or Asian British Minority ethnic population in the East Midlands. More detailed breakdown of the ethnicity statistics is illustrated in Table 1.

**Table 1. Ethnicity in Leicester City (Census 2001)** (adapted from Leicestershire County Council, 2005 and reproduced with permission).

	Leicester	Percent	England & Wales
White: British	169456	60.54%	87.49%
White: Irish	3602	1.29%	1.23%
White: Other White	5681	2.03%	2.59%
Mixed: White and Black Caribbean	2841	1.01%	0.46%
Mixed: White and Black African	539	0.19%	0.15%
Mixed: White and Asian	1908	0.68%	0.36%
Mixed: Other Mixed	1218	0.44%	0.30%
<b>Asian or Asian British: Indian</b>	<b>72033</b>	<b>25.73%</b>	<b>1.99%</b>
<b>Asian or Asian British: Pakistani</b>	<b>4276</b>	<b>1.53%</b>	<b>1.37%</b>
<b>Asian or Asian British: Bangladeshi</b>	<b>1926</b>	<b>0.69%</b>	<b>0.54%</b>
<b>Asian or Asian British: Other Asian</b>	<b>5516</b>	<b>1.97%</b>	<b>0.46%</b>
Black or Black British: Caribbean	4610	1.65%	1.08%
Black or Black British: African	3432	1.23%	0.92%
Black or Black British: Other Black	553	0.20%	0.18%
Chinese	1426	0.51%	0.44%
Other Ethnic Groups	904	0.32%	0.42%

Leicester City is one of the most diverse and disadvantaged urban areas in the country. Within the city, some areas have poorer health and shorter lives than in other areas. It is an old city with a young population. About 45% of Leicester people are under 29. It is a city where English is not commonly spoken as a first language by almost 1 in 5 people<sup>1</sup>. Within the city, there are many areas with a strong sense of community identity. About 2 in every 5 people are from ethnic minorities, and many people belong to the city's 14 different religions. Arising from those religions there are 240 faith groups which meet regularly. The large population of Indian origin has resulted in Leicester having significantly high proportions of residents giving their

<sup>1</sup> (Leicester City PCT website <http://www.leicestercity.nhs.uk/YourHealth-Localhealth.cms> accessed 23.11.09).

religion as Hindu, Sikh or Moslem (see Table 2). Large differences in life expectancy occur in different areas of the city. Leicester is the 20th most deprived area in the UK. It has 13 city wards which are in the 28 most deprived in England, with almost half the population of the city being highly disadvantaged. For example, nearly a fifth of the population does not commonly speak English<sup>2</sup>.

**Table 2. Religion in Leicester City (Census 2001)** (adapted from Leicestershire County Council, 2005 and reproduced with permission).

	Leicester	Percent	England & Wales
Christian	125187	44.72%	71.75%
Buddhist	638	0.23%	0.28%
Hindu	41248	<b>14.74%</b>	<b>1.06%</b>
Jewish	417	0.15%	0.50%
Muslim	30885	<b>11.03%</b>	<b>2.97%</b>
Sikh	11796	<b>4.21%</b>	<b>0.63%</b>
Other religions	1179	0.42%	0.29%
No religion	48789	17.43%	14.81%
Religion not stated	19782	7.07%	7.71%

There are variations in health between ethnic groups apparent in East Midlands. The data on self-reported health from Census 2001 are similar to those in England and Wales as a whole. Appendix 8 illustrates further health statistics which may be of interest to the reader.

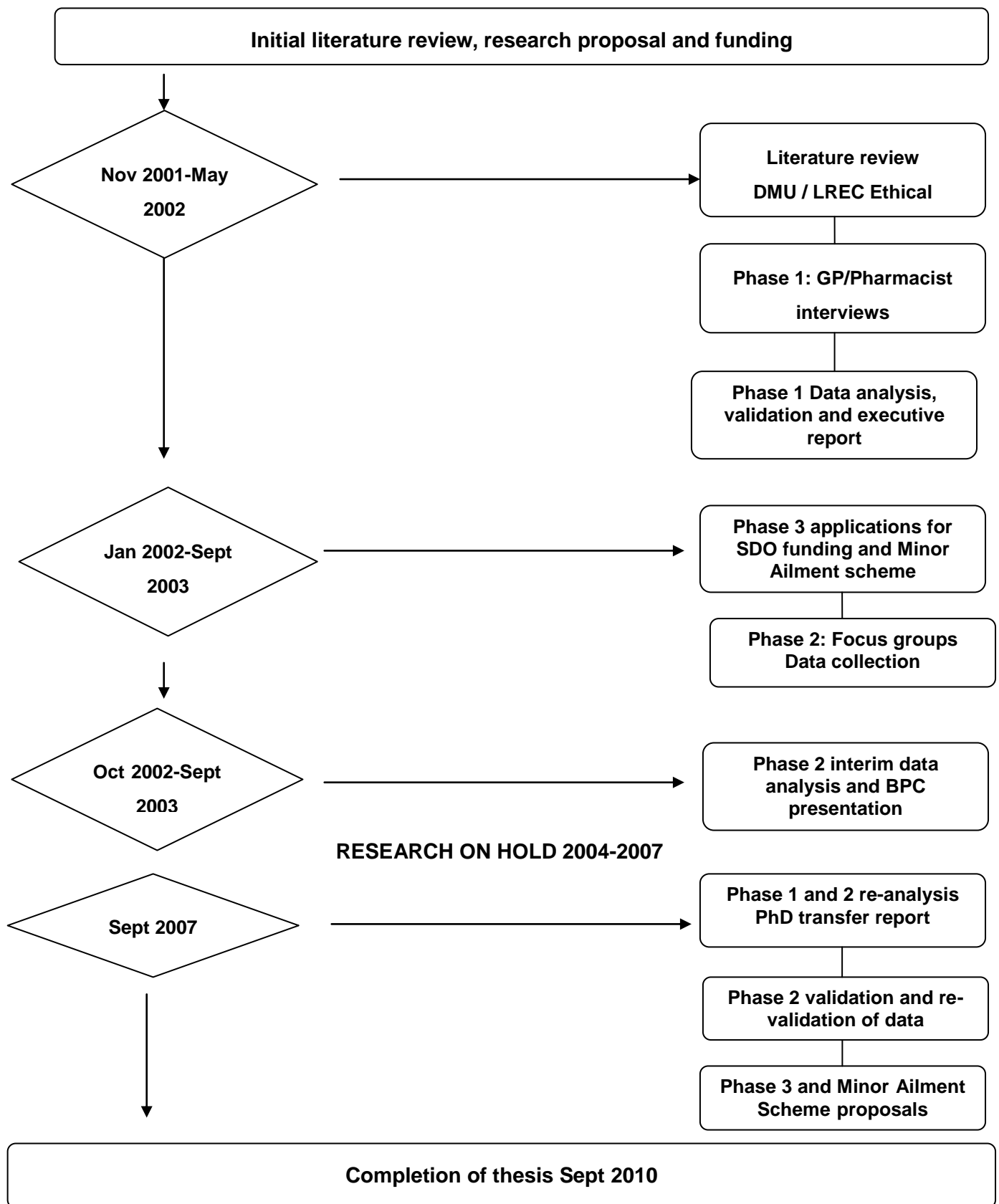
Leicester is forecast to become the first city in the UK to have a 'majority' Black Minority Ethnic (BME) majority population as a result of the Census in 2011. Further research is needed at local level to determine whether, how, and to what degree a reconfiguration of services can result in better management of demand for GP services by the indigenous members of the local population in Leicester City and make better use of community pharmacy services.

<sup>2</sup> (<http://www.leicester.gov.uk/your-council-services/council-and-democracy/city-statistics/demographic-and-cultural/>) (accessed December 2005).

### **The execution of the study**

Figure 2 illustrates the time line for the execution of the study, which was conducted on a part time basis. This study commenced in 2001. Data for the study was collected between 2001 and 2003. Due to circumstances beyond the investigator's control, the study was interrupted in 2004 and recommenced in September 2007. During this period there were a number of key Government policies pertaining to community pharmacy services and their delivery. During the writing of this thesis, the author has attempted to highlight pertinent policy changes and further major research during the period of the study 'interruption' that support or refute any results. This thesis was completed in 2010, almost 10 years after its inception.

**Figure 2. The execution of the PhD study**



## **Organisation of the thesis**

The rest of this thesis includes the following chapters.

**Chapter 2:** This chapter outlines the **definitions and context** of ethnicity and culture, and appraises the relevant NHS Government policies pertaining to the health of the South Asian minority ethnic population. The chapter also includes a critique of the key policies relevant to the reconfiguration of pharmacy services within in the wider NHS re-organisation.

**Chapter 3:** The **literature review** explores and critiques published research that has been done in this area, including the debate on culture in relation to healthcare research. The review includes critical appraisal of pharmacy practice research in relation to South Asians. Selected studies that have researched concepts such as culture and communication in the South Asian population that could be pertinent to community pharmacy have also been appraised, particularly to see if the research methods used could be used for this PhD study. Key studies that have underpinned major reforms to pharmacy policies have been presented where relevant to this thesis, including aspects of professional collaboration.

**Chapter 4:** This chapter explains the **methodological approaches** considered for the study, **the method** and rationale for the data collection. The chapter discusses the use of the analysis techniques used for this study. The use of the 'Social Action Research Model' is described.

**Chapters 5 and 6:** The **main findings and discussion** of the study are illustrated. In Chapter 5 presents and contextualises the views of six general practitioners, five community pharmacists using one to one in depth interviews (Phase 1 of the study). These deliberations are further explored in Phase 2 which involves six focus group interviews with fifty five South Asian participants from Hindu, Moslem and Sikh communities. Chapter 6 presents the findings from these interviews, and the main discussion gives a critical insight into their perceptions of the management of minor ailments, their perceptions of health, knowledge health seeking behaviour patterns, their view of community pharmacy services and knowledge of cultural and religious influences on health and medicines adherence. The discussion contextualizes the main findings for pragmatic interpretation and argument against published research, including a practical synopsis of how the findings can be applied to pharmacy practice and the some of the operational elements of the minor ailments scheme in Leicester City. The author also makes recommendations for future study.

**Chapter 7:** The author concludes the thesis by highlighting how the findings contribute to knowledge and previous research in this area.



# Chapter 2

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## **Definitions and policy context**

## CHAPTER 2. DEFINITIONS AND POLICY CONTEXT

This chapter is set out in three sections.

**Section 2.1:** defines some key concepts relating to ethnicity, culture and 'race'

**Section 2.2:** reviews and summarises the key government policies which relate to the NHS reforms and their relevance to ethnicity

**Section 2.3:** reviews and summarises the key policies which relate to pharmacy services

### SECTION 2.1 Ethnicity, culture, race, diversity and health inequalities

*'A lack of sensitivity to the meanings of categories such as 'race', ethnicity and the concept of racism, alongside the propensity of sociologists of health and illness to keep their heads 'buried in the sand of white health concerns' has all but inhibited the development of an effective body of research' (Annandale, 1997 from Bissell et al, 2003b p 183).*

Health inequalities are differences in health status that are driven by inequalities in society. The classic definition of health inequalities suggested by Whitehead as 'differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust' (Whitehead, 1991). In the most simplistic sense, health inequalities are a consequence of social injustice – they are manifestations of socio-economic variations where the greater the variation in the social determinants of health such as educational attainment, housing quality, employment status and net weekly spending power, the greater the health inequalities gap is likely to be. Health is shaped by many different factors, such as lifestyle, material wealth, educational attainment, job security, housing conditions, psycho-social stress, discrimination and the health services. Health inequalities represent the cumulative effect of these factors over the life-course; they can be passed on from one generation to the next through maternal and family influences on baby and child development. BME groups generally have worse health than the overall population (with some exceptions), although some BME groups fare much worse than others, and patterns vary from one health condition to the next. Evidence suggests that the poorer socio-economic position of BME groups is the main factor driving ethnic health inequalities.

Differences in health across ethnic groups, in terms of both morbidity and mortality, have been repeatedly documented in the UK (Marmot et al. 1984; 2010; Rudat 1994; Nazroo, 1998; 2001; 2003; 2006; Erens et al, 2001). However, the factors underlying such differences remain contested. In particular, the significance of social determinants, particularly the social inequalities that ethnic minority groups face, remains the subject of considerable debate. Some claim that social and economic inequalities make a minimal, or no, contribution to ethnic inequalities in health (Wild and McKeigue 1997); others suggest that even if they do contribute, the cultural and genetic elements of ethnicity must also play a role (Smaje 1996); and others argue that ethnic inequalities in health are predominantly determined by socio-economic inequalities (Sheldon and Parker, 1992). In part, the ongoing debate about the significance of social inequalities to ethnic differences in health is a consequence of the empirical complexity of the field, both in terms of the difficulties of undertaking research and the sometimes poor quality data that result, and in terms of the difficulty of interpreting findings. Reports by Smaje (1995, 1996) also provided a convenient summary of earlier research in the field and without bringing in primary evidence on its own, proved influential in future direction in ethnic health research particularly in its confirmation that ethnicity was deeply embedded within health inequalities.

The author considered it important to use these explanations for this research study and put definitions into context by illustrating what is meant by ethnicity and why it is important to understand how ethnicity, race and culture are interwoven in the understanding of health and health inequalities, particularly from the author's background as a pharmacist.

### ***Race, Culture and ethnicity***

Traditional anthropology defined four major human 'races', usually described as 'Caucasian' ('white' or European), 'Negroid' (Black or African), 'Mongoloid' (Asian, Chinese or Indic), and 'Australoid' (that is, the group of people described as 'Aboriginal' to Australia). These groups assumed that race was a bio-scientific concept explaining significant biological differences between populations. This concept of race is now firmly discredited by modern genetics. Over 99% of the genetic makeup of human beings is common to all ethnic groups. Those differences that do exist between people and populations are minor and largely reflect superficial physical characteristics ('phenotypes') such as facial features, hair or skin colour. In this sense the division of people into 'races' reflects social decisions rather than having any real scientific justification, but is based on fallacious genetic/biological

associations (Johnson, 2004a). 'Culture' is a complex social phenomenon and consists of the shared beliefs, values and attitudes that guide the behaviour of group members. The concept of 'ethnicity' is more complex, but recognises that people identify themselves with a social grouping on cultural grounds including language, lifestyle, religion, food and origins. The basis of 'ethnicity' is thus often a tradition of common descent or intermarriage and shared culture or history. It is essential to recognise that, in a world of migration and mixing, cultures and societies are dynamic rather than fixed. Table 3 compares the concepts of race, culture and ethnicity.

When considering the causes of ill health and approaches to its prevention or care, it is necessary to consider the individual at risk, or the group to which they belong, in a holistic manner. The problem is using categories that most effectively describe key factors relevant to, for example, susceptibility to poor health or health outcomes. For pharmacy, this is an important concept to understand as considerations need to be given to the concept of 'holistic' healthcare approaches, particularly for the prevention of poor health.

**Table 3. Comparing the concepts of race, culture and ethnicity.**

Concept	Primary Characteristics	Origin	Associated perceptions
'Race'	Inherent, Biological, Physical, Nature/Natural	Genetic – Descent	Permanent
Culture	Behavioural Expression of preferred lifestyle	Upbringing – Learned	Capable of being changed, Optional
Ethnicity/ Ethnic Group	Identity, Multi-faceted, 'Political'	Socially constructed – Internal or external – or legal	Situational, Negotiated

After Johnson, M at Centre for Evidence in Ethnicity, Health and Diversity (CEEHD)<sup>3</sup>

The UK Race Relations Act 1976 defined a 'racial group' as 'a group of persons defined by reference to colour, race, nationality or ethnic or national origins...' 'Ethnicity' and 'ethnic group' became more formally defined in UK law by a House of

<sup>3</sup> (<http://ethnic-health.org.uk/> accessed Oct 2009)

Lords decision in 1983 as relating to those with 'a long shared history and a distinct culture'. Other 'relevant' characteristics were 'a common geographic origin or descent from a small number of common ancestors; a common language; a common literature; a common religion and being a minority within a larger community'. Cashmore (1984) described an ethnic group as "a group possessing some degree of coherence and solidarity, composed of people who are, at least latently, aware of having common origins and interests." There is no universally 'accepted' definition of ethnicity. The Department of Health (DH) has explored definitions of 'ethnicity' and 'ethnic groups' and offers the following definition:

*"Whilst race is defined by heritage, colour, physical appearance, and physical characteristics, ethnicity is defined by geographic, political, historical, religious and cultural factors"*  
(DH, 2000a: pg 47).

The definition of ethnicity resulted from many aspects of difference which are socially and politically important in the UK. These include race, culture, religion and nationality, which impact on a person's identity and how they are seen by others. People identify with ethnic groups at many different levels. They may see themselves as British, Asian, Indian, Punjabi and Glaswegian at different times and in different circumstances. However, to allow data to be collected and analysed on a large scale for major epidemiological studies, ethnicity is often treated as a fixed characteristic.

An ethnic group is one which regards itself, or is regarded by others, as a distinct community by virtue of historical and cultural characteristics that will help to distinguish the group from the surrounding community. Two of these characteristics are essential:

- A long shared history, of which the group is conscious as distinguishing it from other groups, and the memory of which keeps it 'alive'; and
- A cultural tradition of its own, including family and social customs and manners, often but not necessarily with religious observance.

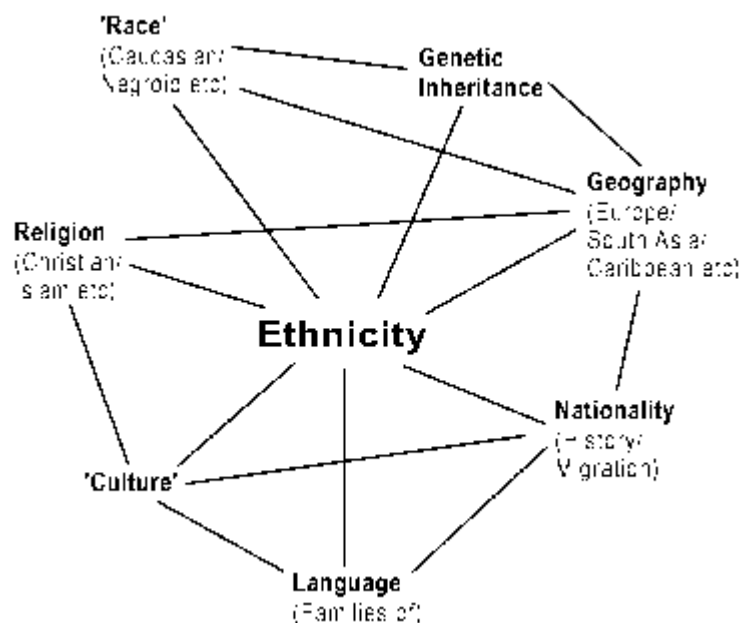
Other relevant characteristics can include one or more of the following:

- A common geographical origin from a small number of common characters
- A common language
- A common literature specific to the group

- A common religion different from that of neighbouring groups or from the general community surrounding it
- Being a minority, being oppressed or a dominant group within a larger community

Hence, the characteristics used to define ethnicity include a number of factual and observable characteristics, but there is also a subjective element which is important to the individual's perception and identification of his/her ethnicity. Figure 3 illustrates one of many possible definitions of ethnicity.

**Figure 3.** An illustrative definition of ethnicity and key factors that contribute to the concept of ethnicity (Johnson 2001 reproduced with permission)



### ***Ethnic health inequalities and its relation to BME groups***

Whilst there is reasonably extensive information on inequalities in health status between ethnic groups in the UK at a national level, much of which comes from surveys, it is notable that comparative (i.e. disaggregated) data on the use of community pharmacy services by the White or BME population has not been included in national Health Surveys to date. In 1999 and 2004, the Health Survey for England (Department of Health, 2001 and 2005c) published a report on the health of BME groups. The results highlighted that BME groups as a whole were more likely to report ill-health, and that ill-health among BME people started at a younger age than in the White British. There was more variation in the rates of some diseases by ethnicity than by other socio-economic factors. However, patterns of ethnic variation

in health are extremely diverse, and inter-link with many overlapping factors. Some BME groups experience worse health than others. For example, surveys commonly show that Pakistani, Bangladeshi and Black-Caribbean people report the poorest health, with Indian, East African Asian and Black African people reporting the same health as White British, and Chinese people report better health. Patterns of ethnic inequalities in health vary from one health condition to the next. Some examples are illustrated in Box 3.

**Box 3. Examples of Patterns of ethnic health inequalities**

BME groups tend to have higher rates of cardio-vascular disease than White British people, but lower rates of many cancers.

Ethnic differences in health vary across age groups, so that the greatest variation by ethnicity is seen among the elderly.

Ethnic differences in health vary between men and women, as well as between geographic areas.

Ethnic differences in health may vary between generations. For example, in some BME groups, rates of ill-health are worse among those born in the UK than in first generation migrants.

A Department of Health report entitled: '*Study of Black, Asian and Ethnic Minority issues*' (Alexander, 1999) formed part of a strategic programme of activities begun in 1998 to progress implementation of the Department's equal opportunities policy, particularly in relation to black, Asian and other ethnic minority people. The review highlighted some recommendations and findings in the areas which could influence the health needs of BME populations. These included reconfiguration of health service delivery, opportunity for the healthcare workforce to develop the skills and knowledge needed for effective integration of diversity into all aspects of healthcare delivery and involvement of BME staff in policy development. The main findings in sections 3 and 4 of the review brought together for the first time, race equality issues relating to the major functions and services for which the Department of Health is responsible. Contained within the body of the report, therefore, were references to many strategic areas. These range from older inner city Asian GPs in single-handed practices to the importance of the minority-led voluntary sector in developing 'social capital'. Examination of these, and many other strategic issues, reinforced the view

that institutional racism exists in many of the Department's operations. The term 'institutional racism' indicates *'the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behavior which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages ethnic minority people. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation. It is a corrosive disease'* (Macpherson, 1999).

However, the report by Alexander (1999) consistently demonstrated that the strong and visible political leadership directing change would be beneficial in addressing how BME groups could have the same opportunities as the white population, encouraging the notion of 'universalism' in policy making. Similarly, a review by Atkinson et al (2001) showed only a few studies which evaluated interventions for improving 'access', and such reports which existed were almost entirely confined to the grey literature. It reveals a large but diverse literature in the field of ethnicity and health and issues directly, or indirectly, related to access. A substantial body of research existed, but this was usually local-policy-led, owned by local institutions and not widely disseminated. At the outset, the authors did not start with a prescriptive definition of the meaning of the term 'access' as applied to black and minority ethnic populations. However, they were able to identify a number of key dimensions which emerged most frequently from the literature as explanations for (anticipated or real) differential uptake or unequal access. These included: 'newness' or user ignorance; language and literacy; cultural differences (covering religion, gender, work patterns, shyness and differential presentation); lack of staff training needs; differential needs of specific populations; and location of service delivery.

The variation in health between and within different ethnic groups can be related to socio-economic status but recent research suggested that current measures of socio-economic status are too insensitive for the exploration of ethnic variations in social position. For certain conditions such as diabetes and coronary heart disease, there is clear evidence that there are variations in health associated with South Asian ethnicity over and above socio-economic status (Balarajan, 1996; Karlsen and Nazroo 2002; Johnson 2004a). Modood et al (1997 p. 338) suggested that generational shifts in identity had been observed, for example, between the migrant generation and the second generation. They go on to say that 'minority identities are



continually changing and reinventing themselves through fusing of majority cultures', and that 'cultural' identities are potentially less stable.

### ***Use of health services by BME groups***

As illustrated previously, there is now considerable empirical evidence to show that there are significant differences in the patterns of morbidity and mortality among the UK population, which are correlated with gender, social class, geographical differences and ethnicity. Studies which have compared the utilisation of services across minority ethnic groups have shown that rates of GP consultations are higher in minority ethnic groups, particularly among South Asian groups. Research on health inequalities among minority ethnic groups has demonstrated inequalities in access to health care services and poorer health outcomes within minority ethnic groups (e.g. prior to this PhD study Gillam, 1990; Gerrish, 2000 and 2001). The Health Survey for England (DH, 2001) also showed that South Asians consulted their GP more frequently than the general population

There was also some evidence of lower access to hospital care among BME groups. South Asians were found to have lower access to care for coronary heart disease. Looking at prevention, rates of smoking cessation were lower in BME groups than in White groups. In addition, rates of dissatisfaction with NHS services were higher among some BME groups than their White British counterparts. These points are also discussed further in Chapter 3. It could be argued that some of these may be 'common' to all health care users and that these points cannot be generalised to cover all members of minority ethnic populations. Men and women have different needs. There are also differences in health care needs for example between young and older people. Data from research exploring health care needs are also affected by geography, pollution, epidemics, and the media. Many BME groups experience higher rates of poverty than the White British, in terms of income, benefits use, worklessness, lacking basic necessities and area deprivation (Platt, 2002). As illustrated previously, much of the variation in self-reported health between and within BME groups can be explained by differences in socio-economic status (Nazroo, 2003). However, Johnson (2001) argues that there is a complex interplay of factors affecting ethnic health, such as the long-term impact of migration, racism and discrimination, poor delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility. The relationship between 'race', ethnicity, culture and health remains contentious. This involves more than identifying a list of ethnic 'groups' who allegedly share the same culture and behave in predetermined

ways. He concluded that there are many factors that relate to differences in minority ethnic people's use of services, both in their likelihood to use a service, and in the way in which the consultation may develop. These are illustrated in Box 4. Most of these factors have been explored in relation to community pharmacy services in this thesis.

**Box 4. Factors that can influence the use of health services by BME members of the population (Johnson, 2001 reproduced with permission)**

Ethnic Differences in Patterns of Disease
Cultural Variations in Presentation of Symptoms of illness
Perceptions of health, body and disease
Cultural and Language differences in Descriptions
Accessibility of Services (time and place)
(previous experiences of) Encounters with Services
Alternative Treatment Options
Lifestyle, religion and cultural practices
Socio-Economic Status
Racism direct, personal, indirect or institutional
Language
Education and the Availability of Information
Attitude, Awareness and Skill of Clinical staff

***Using the concept of culture to explain health behaviour***

As seen in Chapter 1, the principal investigator of this study had observed 'differences' in the way South Asian service users differed from 'white' service users when using pharmacy services, and it was frequently assumed that this may be due to 'cultural' beliefs. There have been different arguments in the literature about the notion of 'culture' or 'cultural health behaviours' contributing to 'poor health' of BME groups. Early health service interventions ended up 'blaming' those cultures for ill-health. This was because such attempts emphasised 'unusual' practices which were then viewed as deviant from the allegedly healthy 'norms' of the ethnic majority. Culley and Dyson (2001) argue that in trying to explain health behaviours by reference to different 'cultures', there is 'ignorance' in the diversity that exists within cultures that are supposedly homogenous. The notion of an 'Asian' 'identity', for instance, is a product of the historical circumstances in which people of disparate and diverse parts of the Asian mainland hundreds of miles apart come to be in Britain.

This means that, for example, some people of Asian birth could well be of Indian, Chinese, Arab as well as African descent (Bhachu, 1985). Hence, more specifically, the term South Asian is used. In addition, the emphasis on cultural difference ignores the extent of similarities between different ethnic groups. For example, Freidson (1970) describes the concept of the 'lay referral network' to express the idea that, before formally becoming patients, those who are ill may check out their symptoms with others, such as family, friends, or work colleagues, in order to assess whether or not they should go to see their doctor. In the author's practice as a community pharmacist, she observed that in addition to self medicating, South Asians also sought 'alternative' treatments from an alternative healer such as a hakim, or referred to a respected religious figure, such as an imam (priest). Other health-seeking behaviours included seeking advice from a mother-in-law or extended family members. Taken in isolation, it would be possible to misrepresent the health behaviours of South Asians as 'different' or as part of their 'culture'. However, these patterns may also be present in other population groups. In other words, while use of a Hakim or extended family member might appear to be South Asian specific, the equivalent in another culture might be a 'traditional Chinese healer', 'bonesetter' (West Indian) or wise woman (in older English culture!) – the names of the members of the lay referral network might be culturally specific or culturally framed, but the activity is universal. However, observers may not recognise this when labelled in such 'exotic' terms by reference to cultural roles such as priest, healer etc.

There is also an argument that cultures are not static but are continually changing and evolving, and that cultural identity is historically and socially situated. There are many factors other than ethnicity that contribute to a culture, and that culture is equally derived from gender, level of income, generation and other power relations as much as ethnicity to which it is too often reduced (Ahmad, 1996, Culley and Dyson, 2001, Johnson, 2001). Ahmad et al (1989, 1990) found that the supposedly 'cultural' preference of Asian women for a female GP was, on closer examination, a preference for a GP who spoke a relevant language. Ahmad (1996) also states that culture may be a source of nurturing and strength. It has been suggested that concentration of some minority ethnic groups in certain residential areas may have positive health effects through community integration and social support, which may even offset any health damage from the poor material environment often found in the urban areas where minority ethnic groups predominantly live. Furthermore, it is conceivable that high levels of unemployment may enable people to undertake extensive lay caring roles, and that an otherwise positive social development in

ending high unemployment rates may break down a hidden lay network of caring only made possible by that unemployment (Mir, 2005). The author's own observations of the 'caring' network was evident in her practice, where service users consulted with extended family members with whom they were living with or being cared for. To some degree, this was sometimes ethically challenging in the way community pharmacists 'negotiate' medicines use and communicate health information with more than one person during a counselling session.

A significant amount of nursing research (e.g. Leininger and McFarland, 2006) concentrates on learning about the principles of a number of cultures and religions and how to respond to a patient's presumed needs on this basis (transcultural nursing). However, many authors argue that this does not meet the flexibility of culture and may indeed lead to harmful stereotyping. Kelleher (1996) argues that ethnicity and culture are likely to be just one set of structures (among others such as age, gender and sexuality) that people use in making sense of their lives and their understanding of health and illness. He suggests that culture may play an important role in showing how individuals and groups construct their identities. Their perceptions of health and illness, how they respond to illness and to treatment regimes are all potentially influenced by the taken-for-granted ideas of their culture as well as the medical/scientific knowledge people are able to draw on through education, the media and the healthcare system. Kelleher (1996) also suggests that this is not to deny the significance of structures of inequality or the reality of racism, but to argue for an approach which extends our knowledge of how people draw upon elements of culture to help them manage the situations they face as patients or providers. This argument is also supported by Culley (2000). Through these arguments, it is implied that ethnic identity not necessarily as a 'barrier' to good health, but also as a potentially positive source of support, which can contribute to the promotion of well-being. While it is undoubtedly the case that culture may influence health in many ways, some of literature published later indicates that one should not view culture in a deterministic way, nor should one ignore the many similarities between ethnic groups in their experience of health and illness (Bissell et al (2003b); Culley, 2006; Phillips, 2007). Bissell et al (2003b) also cite Ahmad's work, in that that there is a lack of consensus about the status of 'race' and ethnicity as explanatory variables within health research. The authors infer that differences in health status are to do with other factors associated rather than ethnicity per se. However, a focus on ethnicity, rather than other associated factors (social class, poor housing, education, racism etc), can lead to the inference that it is ethnicity itself

which causes poor health. It has also been said that such an approach links with victim blaming: that minority groups are themselves responsible for their 'poor' health by virtue of their adherence to deviant 'cultures' or practices which are held to shape health behaviours and health outcomes (Ahmad, 1993). These debates, although complex, help to illustrate some of the problems encountered when concepts such as ethnicity are applied to health. At a political level, this dispute is mirrored around the merits of 'multiculturalism' versus 'anti-racism'. Although it does not have an exact meaning, Bissell et al (2003b) define multiculturalism as an attempt to emphasise the existence and the validity of differing cultural traditions and to promote tolerance and understanding of these traditions. Alternatively, anti-racism, although broadly embracing the multiculturalist perspective, places more emphasis on identifying and changing the forces that structure relationships and determine access to power in society. What is suggested is that dominant ideologies are inherently racialised and racism is seen as a pervasive instrument of social control which marginalises people from ethnic minority populations. Smaje (1996) states that this debate is 'endemic' and complicated within social research. Annandale (1998) pointed out that health education, medicine and the social sciences have colluded in constructing an 'intellectual apartheid' in their conceptualisation of ethnic minority groups as carriers of problematic 'cultures' and 'exotic' illnesses. Similarly, Ahmad (1996) contests that medicine has presented the world of ethnic minority groups as one where cultures are 'lifeless, limp, cellophane-wrapped' . . . rather than cultures that are empowering, changing, challenging and 'flexible'. Health services research assumes 'white' culture as an unstated standard, which Annandale (1998) highlights as a problem. This is also highlighted in the non medical setting by Dyer (1997), one of the few researchers who has suggested (and constructed) 'whiteness' as an 'ethnic' identity. Whiteness is 'unmarked and unnamed' as only 'others' are seen to be carriers of 'culture'. The problem that follows from the use of 'white' culture as an unarticulated standard by which to judge ethnic minority culture, and there is the tendency to subsume people under the oppressive and deterministic cloud of 'cultural difference'. Smaje (1996) also argues that it is this silence about the way in which white culture is constructed that is the biggest omission in research exploring race and health. Lambert and Sevak (1996) surmise that the tendency to focus on culture in research findings is also accentuated by the fact that much research is funded on the assumption that there are fixed distinctions in beliefs and behaviour between different ethnic groups. The aims of such research is based on such assumptions, and the research concentrates on constructing a set of findings that facilitate the provision of more appropriate or culturally sensitive health education messages and health

promotion materials. Hence, a tendency to interpret findings with reference to such beliefs and practices, thereby accentuating or 'muting' such beliefs. By addressing 'culture' it permits health professionals and policy makers to believe that they are attending to the problem in question without having to consider the more politically sensitive problems of poverty, deprivation, discrimination and racism, about which they may not be able to respond effectively. Such empirical approaches have also been criticised for assuming that the problem under consideration rests with 'faulty' health beliefs which are a function of monolithic 'cultural' values (Ahmad, 1996 and also argued by Culley, 2000) and fails to address what may be the more significant causes of health differences. It can also be argued that it is crucial that researchers question assumptions about 'culture' and explore other avenues before assigning 'culture' to a predominant position in their explanations for behaviours. It is suggested that culture is constantly made and re-made- ever changing, fluid and shifting. Kelleher (1996) argues:

*"Researchers who want to use the concepts of culture and ethnicity do not believe . . . that in constructing ethnicity and culture people are simply taking over a fully formed monolithic set of rules for living; . . . the process of culturally based research is not one of digging up a past culture in order to be able to predict precisely in a positivistic way what people believe and how they will behave . . . it is guided by an awareness of some of the problems people in particular ethnic minority groups currently face and a desire to know more about how they perceive a situation and how they are using their cultural resources to address their current problems."*  
(Kelleher, 1996 and also Bissell et al (2003b)).

It can also be argued that some role for culture and the complexity of culture needs to be retained when researching health-related behaviour. Ahmad (1996) and Culley's (Culley, 2000) critique of the notion of 'culture' as an explanation of health inequalities suggests that insufficient attention has been paid to other elements of the process involved, such as the power of structural constraints in the 'race'/socio-political arena. Kelleher (1996), whilst accepting these points, regards ethnicity as a concept which incorporates both the cultural issues situational processes. The problem remains that researchers in the 'ethnic health' field continue to argue, quite rightly, about the central role of culture as a means of expression and a 'lens' through which BME people 'express' their world. Several authors have suggested that one

way to do this is via Bourdieu's notion of habitus (Bourdieu 1990; Smaje 1997). Bourdieu describes habitus in the context of social class, but the analysis can be equally applied to ethnicity. The habitus is a 'socially constituted system of cognitive and motivating structures', which provides individuals with predisposed ways of relating to and categorising both familiar and novel situations. The habitus is formed in the context of people's social locations and inculcates in them a 'world view' based on these positions (Shilling, 1993; page 129). This set of dispositions — what Bourdieu would call "bodily hexis" — operates most often at the level of the unconscious and the mundane and might comprise in the case of ethnicity such things as attitudes to language, dress, diet and customary practices (May, 1999; page 28). A key point is that Bourdieu attempts to overcome the agency/structure dichotomy in positing that habitus does not determine individual behaviour. Choice is possible, but choices are not unlimited. Habitus is a product of socialisation, but also modified by individuals' experiences of the world. It suggests that traditional cultural values and practices do exert considerable influence at the individual and collective levels and may be slower to change than postmodernism would suggest, but habitus also accommodates an ongoing process of cultural construction and 'reconstruction' (Culley, 2006).

It is easy for more simplistic observers and policy makers to reduce their prescriptions for change, or analysis of inequality, to one of 'culturalisation', a tendency pilloried by Culley and Dyson (2001) and Culley (2006). However, there remains a risk that research may rely on the structured attribution of difference to arguments of ethnicity, race, culture etc as fixed entities as providing an apparently authoritative or at least convenient explanation. The author of this study concurs with the arguments put forward by Culley (2000), Kelleher (1996), Johnson (2001), Ahmad (1996) and others that culture is 'fluid'. Culley (2006) argues against the essentialist concept of ethnicity, which underpins most notions of 'transcultural' practice and argues for the possibility of a critical, non-essentialist approach to cultural difference and healthcare practice. Culley (2006) suggests that 'culture' is not seen as fixed, finished or final, which one can sum up in a body of contents, customs and traditions, but a *critical* concept that appropriates some of the theoretical advances of postmodernism.

This thesis did not set out to explore the wider determinants of health inequalities but explores if there are potential 'cultural' influences to the use of community pharmacy services by the South Asian population. The data will illustrate if the arguments set

out above are valid and what aspects of 'culture' need to be understood by community pharmacists in order to meet the health needs (or not as the case might be) for this community. In chapter 3 (page 57), the author attempts to put these empirical notions into context from a pharmacy practice perspective, and develops the arguments for and against these concepts as part of this PhD thesis.

### ***Demographic data collection relating to ethnicity and religious background***

Bhopal and Donaldson (1998) insisted that white people are a heterogeneous group, and the term *white* should therefore be abandoned as a classification for the purposes of epidemiology and health research, and identifications based on geographic origin and migration history be used instead. In addition, they felt there was a need for distinguishing the subgroups of the 'South Asian' population, as South Asians are also a heterogeneous group of people of Indian, Pakistani, Bangladeshi and Sri Lankan origin, with differing religion, language and culture (Alexander, 1998). In the 2001 census, there was also a question on people's religious affiliation – although it was not compulsory. This is illustrated in Table 4 (Page 33)<sup>4</sup>.

At the time of this PhD study, regional and sub-regional information on ethnicity status and health outcomes was quite limited and cautious extrapolation of data from national information was sometimes the only available option for interpreting health outcomes of the local BME population. Limiting factors included lack of relevant regional and local surveys and poor recording of patients' ethnicity by local NHS organizations. Large-scale national surveys were the most useful source of data on ethnic health. For example, under its current design, the Health Survey for England measures ethnic health inequalities every five years. However, ethnicity is not recorded at death registration, so mortality can be estimated only by country of birth. There was also a lack of regular, accurate data to monitor ethnic variation in the use of NHS services. In 1993 the DOH recommended that data on ethnicity should be included as a recorded variable in the NHS patient records. This recording was made compulsory in 1995 for all hospital admissions, but definitions and data collection remain problematic. Many reported cases of differentials in morbidity were therefore subject to bias and open to challenge on the grounds of validity, consistency and reliability. As seen earlier, much of the empirical literature relies on

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<sup>4</sup> (see also <http://www.statistics.gov.uk/census2001/pdfs/H1.pdf> (accessed Jan 2010).



the epidemiological data on ethnicity gleaned from national surveys. The importance of 'ethnic monitoring' has also been highlighted in major reviews (e.g. Johnson and Gill, 1995; Jesson, 1998; Johnson 1999 and 2004a; Culley and Dyson, 2001) and later by Randhawa, 2007; Aspinall and Jacobson, 2007; Johnson, 2008, Iqbal et al (2009). Although the primary purpose of ethnic monitoring is to identify and address any discriminatory patterns, it can also be useful for monitoring local needs for particular ethnic populations, and organizing services so that appropriate 'structures' of service delivery are developed to meet the needs of the local population.

**Table 4. Ascertaining the religious background of census participants (from Census 2001 England Household Form page 6)**

<input type="checkbox"/>	None
<input type="checkbox"/>	Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
<input type="checkbox"/>	Buddhist
<input type="checkbox"/>	Hindu
<input type="checkbox"/>	Jewish
<input type="checkbox"/>	Muslim
<input type="checkbox"/>	Sikh
<input type="checkbox"/>	Any other religion (please write in)

Until 2005, the collection of ethnicity data in the health care setting was only mandatory in secondary care. The Department of Health's (DH) Quality and Outcomes Framework<sup>5</sup> introduced a small financial incentive to GP practices that had complete ethnicity data on their patient profiles (this was only available between 2008 and 2009). However, the patchy ethnicity data in primary care undermines the planning and evaluation of policy and precludes the monitoring of changes over time.

<sup>5</sup> (QOF: [www.qof.ic.nhs.uk](http://www.qof.ic.nhs.uk) (accessed Dec 2010))

The Commission for Racial Equality (CRE) had recommended that the Department of Health accelerate its implementation of ethnic monitoring (DH, 2005b). Currently, there is no requirement by community pharmacists to capture the ethnicity and/or language preferences of service users, which could be a potential barrier to independent evaluation of proposed enhanced services for minority ethnic groups or to conduct targeted, or even 'culturally sensitive' pharmacy services to a population with diverse health beliefs. This thesis will explore such issues and illustrate the advantage for community pharmacists to use this information to plan more tailored services to such populations. The next section examines some of the government policies relating to the NHS reforms and ethnicity, and their relevance to the reforms within pharmacy.

## **SECTION 2.2. Review of key government policies underpinning the study**

Key government policies have aimed to tackle health inequalities in recent years, although to date, ethnicity and its associated 'behavioural/cultural' concepts within the wider health inequalities domain has not been a consistent focus. Alongside these policies, there have been major reforms to the NHS and the configuration of community pharmacy services. This thesis set out to explore the relationship between the SA populations and community pharmacy as a primary care service provider, with special attention to the potential for primary care pharmacists to address observed health differences affecting minority ethnic communities and improving their healthcare. The principal investigator wanted to explore if the recent NHS service reconfigurations relating to community pharmacy were known to South Asian service users and GPs. In particular, the research was also concerned about the influences of cultural/ behavioural aspects such as communication, dietary habits, behaviours relating to their use of medicines and preventative aspects of health (self care and the management of minor ailments). As seen in the previous section, 'ethnicity' and 'culture' are embedded within the concept of 'ethnic' health inequalities. The purpose of this section is to highlight aspects of ethnicity and health inequalities in relation to NHS policies, including community pharmacy services. Have the plethora of NHS reforms and pharmacy services reforms considered the needs of the BME population? In particular, what aspects of these policies are relevant to pharmacy practice?

Table 5 gives an overview of key policies.

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**Table 5. Key policies on Health inequalities, NHS and community pharmacy service reforms (1980-2010)**

<b>Year</b>	<b>Policy context in relation to Health inequalities</b>	<b>Policy context for NHS reforms</b>	<b>Policy context for Pharmacy / key government reports</b>	<b>Implications for pharmacy services</b>	<b>Ethnic minority dimension</b>
1980	Inequalities in Health: Report of a research working group. (Black, 1980).			Nothing specific mentioned	yes
1986			Pharmacy. A report to the Nuffield Foundation (Committee of inquiry, 1986)	Yes	None
1987		Promoting better health (DH, 1987)		Support for pharmacies to display health education and promotion material	Mentions inner city deprivation
1991		The Patient's Charter (DH, 1991).		Nothing specific mentioned	Respect for culture and diversity
1992		Health of the Nation (DH, 1992)		Little recognition of a role for pharmacy	yes
1996		Choice and Opportunity: Primary Care in the Future (DH 1996)		Yes-a new 'role' in primary health care team	none
1997		The New NHS : Modern and Dependable (DH,1997)		Nothing specific mentioned	none
1998	Independent Inquiry into Inequalities in Health (Acheson, 1998)			Nothing specific mentioned	Yes

Year	Policy context in relation to Health inequalities	Policy context for NHS reforms	Policy context for Pharmacy / key government reports	Implications for pharmacy services	Ethnic minority dimension
1998		Our Healthier Nation white paper (Related to England only) (DH,1998)		Led to review of pharmacy-related evidence.	None
2000	Race Relations (Amendment) Act 2000			Yes (equity in service delivery) but no specific mention of application in pharmacy	Yes
2000		The NHS Plan (DH 2000c)		Yes	Yes
2000			Pharmacy in the future: implementing the NHS Plan (DH, 2000b)	Significant. Collaborative working encouraged.	None
2000		The Vital Connection: An equalities framework for the NHS (DH, 2000d)		None	Yes
2003	Tackling Health Inequalities: A Programme for Action (DH, 2003b).			Recognition of pharmacy public health roles	Yes
2003			A Vision for Pharmacy in the New NHS (DH, 2003a).	Significant. Introduction of non medical prescribing and medicines use reviews (MURs)	Minimal
2004		The NHS Improvement Plan (DH, 2004a)		Nothing specific mentioned	Yes
2004		National Standards, Local Action Health and Social Care Standards and Planning		Significant mention of the involvement of community pharmacy services	minimal

Year	Policy context in relation to Health inequalities	Policy context for NHS reforms	Policy context for Pharmacy / key government reports	Implications for pharmacy services	Ethnic minority dimension
		Framework 2005/06–2007/08 (DH, 2004b).			
2004		Choosing Health- making healthier choices easier (DH 2004c)		Pharmaceutical public health recognised. Specific mention for community pharmacy services	Yes
2005			Choosing Health through Pharmacy (DH, 2005a)	Significant implications for public health initiatives through community pharmacy	Yes
2005			The new Community Pharmacy Contractual Framework (CPCF) (DH, 2005d)	Endorsement of the configuration of the framework	Yes
2005		Race Equality Scheme 2005-2008. (NHS professionals 2005)		Significant: impacts on the new contractual pharmacy framework	Yes
2005		A practical guide to ethnic monitoring in the NHS and social care (DH 2005b)		No	Yes
2005		Health reform in England: update and next steps (DH 2005e)		Nothing specific mentioned	None
2006		Our Health, Our Care, Our Say a new direction for community services (DH, 2006)		Nothing significant mentioned	Yes in relation to diversity
2007		Commissioning framework for health and well-being (DH, 2007c)		Introduces Joint Strategic Needs Assessments (JSNAs) and significant opportunity for	Yes

Year	Policy context in relation to Health inequalities	Policy context for NHS reforms	Policy context for Pharmacy / key government reports	Implications for pharmacy services	Ethnic minority dimension
				pharmacy enhanced service commissioning	
2008		Healthy Weight, Healthy Lives: A cross government strategy for England. (DH, 2008g)		Indirect recognition as 'health care professional'	Yes
2008	Health Inequalities: Progress and the Next Steps (DH, 2008h)			Pharmacy's public health role to be increased still further	Yes
2008		High Quality Care for All, (DH, 2008c)		No mention of pharmacy but significant implications. The concept of 'one stop' health centres introduced.	Yes
2008			Pharmacy in England: building on strengths - delivering the future (DH, 2008b)	Introduction of Pharmaceutical Needs assessments (PNAs)	Yes
2009		A year of progress towards High Quality Care for All (DH, 2009)		No mention	None
2009		Transforming Community Services: Ambition, Action, Achievement (DOH, 2009)		No mention	Yes
2010		Equity and excellence: Liberating the NHS (DH 2010)		yes	Yes
2010	Fair Society, Healthy Lives. (Marmot Review Team 2010)			yes	Yes

It can be seen that, especially in the period leading up to, and during, data collection for this thesis, there were few documents which included attention to *both* ethnicity and pharmacy: where both were found to be mentioned in the same document, there was no connection made between the two themes.



The Black Report (Black, 1980) was published in 1980 and attempted to explain the rising trend in health inequalities. The report recommended improvements in the material condition of life of the poorest people, especially children, coupled with a re-orientation of health and social services. Although little priority was given by the government at that time to implementing their recommendations (as the report had been commissioned by a Labour government but was published just as a Conservative one came into power), the report was widely disseminated and proved to be influential subsequently in research and public health debates in many countries. It was not till 18 years later when the new Labour Government came into power that Sir Donald Acheson published his report *Independent Inquiry into Inequalities in Health* (Acheson, 1998). This was also a time when key considerations in relation to tackling health inequalities were being addressed in the Governments' National Health Service reforms. The report highlighted variations in health between ethnic populations and made three key recommendations for reducing BME health inequalities. The recommendations stated that:

- policies on reducing socio-economic inequalities should consider the needs of BME groups;
- services should be sensitive to the needs of BME groups and promote awareness of their health risks;
- the needs of BME groups should be specifically considered in planning and providing health care.

The report put a strong emphasis on the effects of wider inequalities, poverty and social exclusion on health inequalities. There is no mention of the involvement of community pharmacy services in helping reduce these inequalities.

Nonetheless, further reports show that health inequalities have increased nationally since 1997. Twelve departments signed up to cross-government work on health inequalities in the Department of Health report *Tackling Health Inequalities: A Programme for Action* (DH, 2003b). This report set out plans to tackle health inequalities over the next three years. It established the foundations required to achieve the challenging national target for 2010 to reduce the gap in infant mortality across social groups, and raise life expectancy in the most disadvantaged areas faster than elsewhere. The main policy targets all focussed on socio-economic class and area deprivation, rather than ethnic inequalities. The report indicated that the gap in life expectancy had increased by 2% for men and 8% for women, while the gap in infant mortality had increased by 6%. There are numerous opportunities within this

strategy that mention the use of community pharmacy services to meet national targets. However, ethnicity had not been a consistent focus of health inequalities policies between the publication of Black and Acheson reports, and few policies had been specifically targeted at BME groups (Exworthy et al, 2003). The report concluded that two important factors affecting the feasibility and likelihood of action on ethnic health inequalities were (and still are) the lack of availability of data on ethnicity, and legal obligations towards racial equality. Exworthy et al (2003) state:

*‘Service provision must be better matched to need if the national target is to be met. The “one size fits all” NHS has not produced equitable health outcomes. Year on year some areas and groups have been subject to poorer access to services, a postcode lottery of care, more ill health and earlier death’.* (Exworthy et al (2003) section 4.12)

Two further government reports on tackling health inequalities have been published since 2003. They include Health Inequalities: Progress and the Next Steps (DH, 2008) and the Marmot review (DH, 2010). It is notable that many of the recommendations in these reports echo those of previous reports. However, unlike the Black and Acheson reports, the role of community pharmacists contributing to the wider health inequalities agenda through public health initiatives has been recognised by the main health inequalities policies in 2003, 2008 and 2010 (Table 5). Nevertheless, despite the plethora of NHS reforms introduced between 1990 and 2010, the inequalities gap still remains significant.

From Table 5 it can be seen that there was significant activity in the re-organisation of the NHS over this period. The introduction of the Patients Charter (DH, 1991) introduces the involvement of members of the public in local decision making and clearly stipulates that patients receive courteous and efficient services from NHS staff and to *‘show respect for their customs, religious and cultural beliefs’*. The NHS modern and dependable (DH, 1997) also outlines key drivers for the reforms. These include a more active approach to devolving NHS operations to a more local level, and that strategies should involve more collaborative working between health and social care. The reforms also include modernising communication systems through the National programme for Information Technology (NPfIT) and the introduction of the telephone help line (NHS Direct). The policies also set out the proposed 'Contract for health' as a partnership between the Government, local organisations

and individuals. The aim of the reforms was to improve people's living conditions and health. GP contractual arrangements were also being reformed.

The need to reduce the widening inequalities in health is featured in the main policies relating to public health (DH, 1992, 1998, 2004c), which imply that preventing avoidable illness would allow concentration of resources on other health conditions. Improvements in factors which affect health were targeted, including individual lifestyle behaviours, social and economic aspects, the environment and access to services. The Government aimed to improve the health of the population in terms of lifespan and years free of disease, and to improve the health of the worst off in society thereby reducing the health gap. Action was to take place in the settings of schools, workplaces and neighbourhoods. Targets were initially set for 2010 and included deaths from heart disease and strokes to be reduced by a further third in people aged under 65, accidents to be reduced by a fifth, deaths from cancer in people under 65 to be reduced by a further fifth and in mental health a reduction by a further sixth of deaths from suicide and undetermined injury. The operational logistics were to be determined at local level by PCTs and monitored through 'targets' set in the GPs contractual arrangements (the Quality Outcomes framework, QOF). National Service Frameworks (NSFs) were introduced to provide a framework to carry out the reforms. In many of the White papers, reference to the research evidence underpinning the recommendations is 'patchy'; many give examples of 'good practice' but not of evaluation. What is still obvious that the initiatives still rely on the 'bio-medical' model of lifestyle adjustment and changing behaviours. Monitoring of health data relating to the various 'targets' was to be done via epidemiological analysis and ascertaining economic impact of health reforms, as opposed to ascertaining health outcomes and patient experience of services. Reference to BME ethnic minorities was minimal.

Under the Race Relations Amendment Act (2000), all public bodies have a legal obligation to outlaw racial discrimination and promote equal opportunities by:

- producing a Racial Equality Scheme;
- carrying out a Race Equality Impact Assessment on all new and proposed policies;
- monitoring outcomes by ethnic group.

Reports by the Audit Commission, CRE and others have, however, observed that these obligations have rarely been complied with at local levels. Nevertheless, commitments to improving health service use by BME groups are laid out in the Department of Health's *Race Equality Scheme 2005-2008*. (NHS professionals,

2005). The Commission for Racial Equality, Equal Opportunities Commission and Disability Rights Commission (CRE) (now known as the Commission for Equality and Human Rights (EHRC)) had recommended that the Department of Health accelerate its implementation of ethnic monitoring (DH, 2005b). One of the main questions that was raised from the literature in the previous section is how data collection relating to ethnicity and ethnic needs (e.g. communication needs and need for interpreters etc) was going to be monitored. Although guidance for ethnic monitoring was recommended in the Race Relations Act it was not compulsory for GP systems to capture specific data pertaining to ethnic or religious backgrounds, although required for hospital 'inpatient' events – again, often an obligation often ignored in practice (Johnson, 2008). This guidance was strengthened in 2005 (DH 2005c) when capturing the ethnicity background was incentivised through the GP contractual arrangements as part of their QOF targets for a short period (dropped in 2009). This guide does not stipulate capturing this information for community pharmacy, even though they also provide NHS contractual services.

More recently, following the 'single' Equality Act (2010) which reorganised the various commissions and legislation against discrimination into a single framework under the EHRC, the Department of Health has championed the development of Single Equality Schemes (SES) which are based around six equality strands – race, gender, disability, age, sexual orientation, and religion and belief. Primary Care Trusts (PCTs) are expected to develop their own SES. More notably, PCTs are required to undertake an Equality Impact Assessment (EqIA) of all policies and functions and devise appropriate action plans. EqIAs are a way of examining the main policies and processes of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address real or potential inequalities resulting from policy and practice development. An EqIA should cover all of the six strands of diversity. However data collection for the PhD study had been completed at the time of this policy change, and such areas could not be explored.

In 2005, the government decided to devolve power to PCTs to commission NHS and social services even closer to local level. Policies relating to Practice Based Commissioning (PBC) were introduced in 2005 (DH 2005e, and updated in 2007 (DH, 2007c). It is believed that GP practices are in the best position to understand the needs of their local populations and it is expected that all PCTs should encourage their practices to do so. In October 2006, there was a reconfiguration of Strategic

Health Authorities and Primary Care Trusts. This was to fulfill a key policy objective of restructuring the NHS so it could more easily deliver the Government's vision for a patient led NHS (DH 2005b). This could have implications for the commissioning of future community pharmacy services.

Lord Darzi outlines this in his interim reports ('Our NHS our Future' DH 2007). It was anticipated in that, for example, people would have greater access to GPs through different models of health care, such as polyclinics. He has suggested that these 'polyclinics' may house up to 20 GPs together with a similar number of specialist physicians, plus professionals such as pharmacists. Lord Darzi's final report has been published (DH, 2008c), and an update has been published in 2009 (DH, 2009). Significant reference is made in this to collaborative working with community pharmacists and other healthcare professionals, but Darzi's report did not refer to ethnicity or other aspects of health inequality as benefitting from his recommendations.

### ***Research 'quality' underpinning the key policies***

It can be concluded from the policy appraisal above that, to date, despite ambitious recommendations, there is little evidence based research to support or underpin the recommendations in NHS policies. It has been suggested that the NHS, particularly primary care, has not always catered well to a multi-ethnic population and does not always offer healthcare which is easily accessible and 'culturally competent'. The evidence base on service use and quality in relation to delivery to diverse populations, however, is less well developed than that on ethnic differences in health *per se*. Nevertheless several studies have shown that some minority ethnic users report higher levels of dissatisfaction with NHS services, especially in primary care (DH, 2008) and there are some examples of serious lapses in service provision (Aspinall and Jacobson, 2004). A wider debate on the operationalisation of policies and recommendations in government inquiries has also been highlighted in a critical report (Exworthy et al, 2003) and includes the following points:

- there were no priorities indicated among the recommendations;
- there was no mention of mechanisms or processes to expedite the recommendations;
- the underpinning evidence did not always match the recommendations;
- the recommendations ranged from the general to the specific; and economic evidence and perspectives were lacking

Alexander (1998) reports that robust research evidence underpinning policies in important areas of black, Asian and ethnic minority health is lacking. This is also shown in further systematic reviews by Johnson (1998) and Atkinson et al (2001). The following observations were noted in the systematic review by Johnson (1998).

- Some NHS research explicitly excluded BME involvement
- Most research in which black, Asian and ethnic minority people have been explicitly involved had been short-term in its nature, funded by specific project money, and it tended also to be qualitative rather than quantitative in its approach;
- Research undertaken from BME perspectives did not necessarily exclude or prove irrelevant to, the needs of the majority 'white' populations.

Overall, these reviews illustrated that there was a poor understanding among health professionals of the range of evaluative techniques available; a lack of appropriate analysis even where data were collected; a particular deficiency in the evaluation of organisational interventions and a total absence of economic evaluations of any interventions. There was an emphasis on short-termism, with much innovation being project-based and disappearing when funding ends, a lack of co-ordination of research and development existed, resulting in much 're-invention of the wheel'; and most importantly, a general lack of evaluation at the end of projects. Randhawa (2007) also stated that despite a range of national and local initiatives it was difficult to assess the degree of progress in reducing health inequalities in the absence of robust evaluations of many interventions. This, of course, is made more difficult by the lack of reliable ethnicity data in the NHS, especially data from primary care. A recent Healthcare Commission report pointed out that there are no data on ethnicity for 90% of all contacts that patients have with their general practitioners (Healthcare Commission, 2009).

The next section discusses the relevance of these policies to community pharmacy.

### **SECTION 2. 3. Policy context for reformation in community pharmacy services**

Community pharmacies are privately owned businesses contracted by the National Health Service (NHS) to provide pharmaceutical services. Prior to 1948 dispensing accounted for less than 10% of pharmacists' income, but following the creation of the NHS, 94% of people obtained their medicines from a registered pharmacy and dispensing activity grew, quickly forming the major source of income. This changed the nature of community pharmacy, with pharmacists moving from the front of the shop to the back, working in the dispensary. During the 1950s and 60s prescription volumes continued to rise. As increasing numbers of medicines became available in tablet form, the need for pharmacists to compound medicines from constituent ingredients was dramatically reduced and pharmacists began to fade from the public view as access to them declined (Harding and Taylor, 2001). In contrast to the plethora of government policies relating to NHS reforms, the response from the pharmacy profession in the early 1980s has been 'muted'.

By the early 1980s uncertainty about the future of pharmacy was widespread. In 1983 the Nuffield Foundation commissioned an inquiry into pharmacy 'to consider the present and future structure of the practice of pharmacy and its potential contribution to health care and to review the education and training of pharmacists accordingly'. The Nuffield Report published in 1986 highlighted the 'distinctive and indispensable contribution' of pharmacy to health care (Committee of Enquiry, 1986). But, despite the Nuffield report, the author of this PhD study observed that very little progress, if any, was apparent in the community pharmacy practice contract and very few research studies. Since the late 1990s, Government plans stressed the role of pharmacy as an integral part of the NHS, emphasising its contribution to the delivery of high quality NHS services as part of the Government's declared intention to create a more flexible, choice-orientated health care service.

In 1996 the White Paper *Choice and Opportunity: Primary Care in the Future* DH, (1996) emphasised the need for community pharmacists to become more involved in the Primary Health Care Team. The 1997 White Paper, *The New NHS, Modern and Dependable* (DH, 1997), signalled further changes by giving professionals who made prescribing and referral decisions more financial and clinical responsibility. The publication of the government's public health white paper *Our healthier nation: a contract for health* in 1998 (DH, 1998) created the impetus to reconfigure a number of activities that had entered mainstream pharmacy as "pharmaceutical public

health". This was defined as "the application of pharmaceutical knowledge, skills and resources to the science and art of preventing disease, prolonging life, promoting, protecting and improving health for all through organised efforts of society". (Walker, 2000). Twenty two pharmaceutical public health roles were identified. These ranged from core pharmacy activities, such as providing advice on how medicines work, to supplementary pharmaceutical roles such as maintaining patient medication records, and more general public health activities such as participating in health promotion campaigns. Most were to be provided from community pharmacies. The white paper (DH, 1998) also discussed individuals and health and tackling the wider causes of ill-health within communities. The plan deals with the specific issues of cancer, coronary heart disease and stroke, accidents, and mental health. It also looks at wider issues such as sexual health, tackling drug and alcohol problems, communicable disease, genetics and improving ethnic minorities' health. However, pharmacy practice research and the research underpinning these initiatives was not illustrated in this report, and a review of the research underpinning these initiatives was commissioned (Anderson et al (2003a, 2003b- see chapter 3 page 119).

Following on from this, in the context of large scale reform the white paper '*Pharmacy in the future: implementing the NHS Plan*' (DH, 2000b) defined the strategy of pharmacy services in new NHS reforms. The policy recommended that primary care groups should consider a pro-active pharmacy input and their emphasis to be on local communities, improving services and increasing the quality of care. This included a more pro-active role for the community pharmacist in delivering ambitious new services which could contribute to a reduction of the drug budget for the NHS. The paper outlined plans for giving patients better access to pharmacy services and for helping them to use medicines more effectively. The White Paper recommended that community pharmacy services needed restructuring to meet the needs of patients and to integrate more closely with other local services. The number of community pharmacies would be increased, out of hours coverage would be improved and more use would be made of electronic prescribing. Services were to be restructured to meet the needs of patients and potentially integrated more closely with other local services. Prescribing rights would be extended to include suitably qualified pharmacists. New arrangements would be put in place for training and accreditation. Clinical governance and a new system of professional regulation would ensure quality and accountability in pharmacy services. The document concluded that this programme of change presented a challenge for pharmacy, but suggested its implementation would bring great benefits for patients and pharmacies.



*'Pharmacy in the Future'* (DH, 2000b) suggested the delivery of new ways of care to the community. The paper included a reconfiguration of the Pharmacy contract for community pharmacies, and a framework to include three 'tiers' of services, which include essential services, advanced services and enhanced services and part of a revised contract for Community Pharmacy. However the White paper (DH, 2000b) highlights that the use of community pharmacy as a health care resource is not uniform across groups in the population. In the current regulations, the establishment of new community pharmacy premises was subject to the 'Control of Entry regulations 1992'<sup>6</sup>. In July 2003, publication of the Government's response to the Office of Fair Trading highlighted that competition and choice were important drivers for improving the range and quality of pharmacy services. The report on the control of entry regulations and retail pharmacy services in the UK (DH, 2003c) implied that new pharmacies could be established provided that they remain open 100 hours a week. However in relation to exemptions from the Control of Entry regulations, an exemption may only be given if the pharmacy is going to provide a "full and prescribed range of services, appropriate to local needs, as determined by the PCT". This was perceived to be a threat to existing pharmacies commonly positioned on the high street, threatening their current existence in a fiercely competitive commercial environment. The regulation was brought about as a result of the commitment in the New NHS Plan which highlighted the need for improved access to health care professionals. A discussion paper (DH, 2002) set out the Department of Health's views on the changes that were needed to make the best use of the pharmacy workforce to deliver the aims of *'Pharmacy in the Future.'*(DH, 2000b). Radical new ways of achieving the correct skill mix in community pharmacy staff and training were outlined in order to achieve the priorities for Pharmacy in the Future. In 2002, the Department of Health piloted the Local Pharmaceutical Services (LPS) contract. These were local contracts intended to deliver local priorities, make better use of pharmacists' skills and enable pharmacists to work more closely with other health professionals. However, plans for a new national contract, which was being developed during the first wave of pilots, incorporated these aims (see below) and inhibited take-up amongst pharmacists. Government identified the three major challenges for pharmacy as meeting the changing needs of patients, maintaining

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<sup>6</sup> The control of entry regulations in England and Wales are contained in the National Health Service (Pharmaceutical Services) Regulations 1992; in Scotland in the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995; and in Northern Ireland in the Pharmaceutical Services Regulations (Northern Ireland) 1997. They are referred to as 'the control of entry regulations 1992'.

professional standards and responding to a changing environment (NHS Information Centre, 1999).

*A Vision for Pharmacy in the New NHS (DH, 2003a) contained proposals to modernise the contractual framework for community pharmacy in England. The paper described the progress that pharmacy has made against the targets set in 'Pharmacy in the Future' (DH, 2000b) and provided a vision for future developments. The paper had clear signposts on the future direction of both hospital and community pharmacy service development. For example it states that "Pharmacy is an integral part of the NHS family. We want to see pharmacists strengthening their contribution to the provision of high quality, patient centered NHS services."* The paper particularly emphasized the role for community pharmacists in the public health agenda and medicines management, and stressed the importance of having a pharmacist on the Professional Executive Committees (PEC) at PCTs. The consultation document accompanying this paper also stated that:

*'Community pharmacies are not just another shop on the high street or in the retail centre. We believe they should be clearly seen as places where patients are able to access readily an increasing range of healthcare services. They are a valuable resource for improving health and reducing health inequalities, especially for vulnerable and deprived populations. Community pharmacy can offer a fulfilling career for pharmacists and their support staff, attracting future generations of young people to the profession and encouraging those who have left to return..... 'National Service Frameworks set standards and help reduce unacceptable variations in service quality. We are committed to ensuring that emerging NSFs address the effective use of medicines as an important and integral part of high quality patient care. In developing the diabetes, renal, and long term conditions NSFs, we are drawing together existing guidance and good practice to provide practical support on medicines management. And the Children's NSF will highlight the role of community pharmacists in supporting and advising parents and children on self-care for minor ailments'. (Section 2.13).*

The white paper stated that five things were necessary to make the vision for pharmacy a reality. These are:

- Effective and appropriate arrangements for managing and paying for community pharmacy
- More staff working in different ways

- Better information management and technology
- A robust supporting infrastructure
- Strong professional leadership

Section 3 of the paper concentrates on Community Pharmacy services. *Pharmacy in the Future* (DH, 2000b) highlighted community pharmacists as being well placed to help people cope with everyday health problems. *Pharmacy in the Future* stated that by 2004, every PCT would have schemes in place so that people get more help from pharmacists in using their medicines. The paper suggested that minor ailment schemes may help to achieve this target, and also assist PCTs to achieve several of the objectives for community pharmacy in *A Vision for Pharmacy in the new NHS*. (DH, 2003b). Hence, the concept of minor ailments schemes was explored in this PhD study for the South Asian population and some of the key research studies in the literature have been appraised in Chapter 3 (page 70).

Since initial data collection for this PhD study, two key documents which outlined the basis of a new national contractual framework for pharmacy in England have come into effect. The white paper *Choosing Health through Pharmacy* (DH, 2005a) supported the main white paper *Choosing Health: Making healthy choices easier* (DH, 2004c) and specifically identified how pharmacists and their staff in all NHS sectors could maximise their contribution to improving health and reducing health inequalities, by developing new services and by further extending their roles as advocates for health. The new Community Pharmacy Contractual Framework (CPCF) (DH, 2005d) outlined the framework of a revised pharmaceutical contract and was published after the data was collected for this PhD study. The new contract also brings to fruition the objectives set out in *A Vision for Pharmacy in the New NHS* (DH, 2003a). The new contract draws on the community pharmacy's assets of the skills, expertise and experience of pharmacists, their staff and its presence in the heart of the communities together with a tradition of ready access to all. The contract states that that community pharmacy should:

- be – and be seen to be – an integral part of the NHS family in providing primary care and community services;
- support patients who wish to care for themselves;
- respond to the diverse needs of patients and communities;
- be a source of innovation in the delivery of services;
- help deliver the aspirations within the National Service Frameworks;

- help tackle health inequalities.

An outline of the changes in service delivery are illustrated below.

**Essential** services must be provided by all community pharmacy contractors under the new arrangements. Dispensing is a key service under this heading. In addition, repeat dispensing as an “essential service” in the new pharmacy contract will ensure that standards for GP practices related to the waiting time for requests for repeat prescriptions are much easier to achieve. Other key essential services include clinical governance, the disposal of unwanted medicines, support for self care, sign posting to other health and social care services and public health initiatives including promotion of health lifestyles. For support of self care, pharmacies will help people manage minor ailments and common conditions, including dealing with referrals from NHS Direct. Public health initiatives would include the mandatory display of and distribution of leaflets provided by the PCT. Each year pharmacies are required to participate in up to six campaigns at the request of the PCT. Sign posting services require pharmacies to help people who ask for assistance by directing them to the most appropriate source of help for their health and social care needs. An important tier of service also includes the implementation of ‘Clinical Governance’ arrangements. As part of the Clinical Governance requirements, pharmacies have to participate in clinical audit of their services and have arrangements in place to verify the quality of advice provided to patients. They must have procedures for providing information to patients, obtaining views from patients including their satisfaction with community pharmacy services. Pharmacies must also have staff management, training and development procedures in place for their staff, and ensure handling of all data meets legal and ethical requirements including confidentiality and data protection. Contractors are required to ensure that there are confidentiality policies in place for all staff and that they are appropriately trained.

**Advanced** services require accreditation of the pharmacist providing the service and/or specific requirements to be met regarding premises. A key service here is the Medicines Use Review (MUR). The aim of this service is to improve patient knowledge, concordance and use of medicines. The review involves identifying problems with a patient’s medicines, providing advice to the patient and where appropriate, suggesting changes to the regimen to the patient’s GP. Reviews will normally be carried out face to face with the patient. Telephone reviews are permitted, but only when it is not practical for the patient to visit the pharmacy. This

policy reflects recognition that community pharmacists can play an important role in the management of long-term conditions. A fee per review undertaken is payable, subject to a maximum number of reviews. Good communication and working relationships with local GPs are important in ensuring that the process runs smoothly. To be eligible to deliver Advanced Services, pharmacists are required to be formally accredited on the basis of a post registration qualification. Such services necessitate the pharmacy premises to include quality measures such as private consultation areas.

**Enhanced services** are commissioned locally by PCTs under the new contract based on local needs. The redesign of services requires good inter-professional relationships at local level and may require local commissioners to develop targeted resources, structures and policies to encourage progress in these areas. In broad terms, the Government aims to encourage integration of pharmacists into the healthcare team and increase the range of services provided through the new pharmacy contract. This parallels the introduction of the new General Medical Services (GMS) contract for general practitioner services. The flexibilities in the new GMS contract enable PCTs to develop enhanced roles for a wide range of healthcare professionals. To implement the new GMS contract, PCTs have been advised to consider in parallel how community pharmacy services can be developed to support the GMS contract. PCTs are also asked to ensure that services are commissioned from a wide range of providers, including community pharmacy, for example, commissioning a minor ailment scheme as a local enhanced service in the new pharmacy contract. Such a service will support patient choice for the treatment of self-limiting conditions, help to ease the burden on GP practices, in turn helping deliver access targets and supplement out of hours services. The potential exists to use the commissioning of enhanced services to help drive the redesign of services, move them closer to patients and reduce the demand for other services. These services have been cited in the previous white papers and have been piloted in many areas of the country in community pharmacies, including a Minor Ailments scheme for Leicester City. Some services also include those cited in the Pharmacy White Paper for Public Health (DH, 2005a). Essential and advanced services from the 'nationally agreed' services and are not open to local negotiation. About fifty per cent of budgeted remuneration for pharmacies is in the form of fees and allowances paid from a 'global sum' budget. Pharmacies also receive fees and allowances from their PCTs. The main one is the 'practice payment', which is a monthly payment for smaller pharmacies, or a fee per item dispensed for pharmacies dispensing more

than a threshold level of items per month. A third source of community pharmacies' remuneration is the 'retained margin' i.e. the margin arising from the difference between the price at which a pharmacy purchases a medicine and the price at which the pharmacy is reimbursed by the NHS when the medicine is dispensed. With regard to the latter, new pricing arrangements that came into operation as part of the contractual framework in April 2005, reduced reimbursement prices for generic drugs that are dispensed in high volumes.

This thesis explores the views of participants about the vision for community pharmacy changes envisaged, and will show that despite the vision for changes in the community pharmacy contract, GPs and the participants in this study were not aware about any of the proposed changes in service delivery. The findings will also show that service users welcome most of the initiatives suggested in the new Pharmacy contract, but that further 'marketing' of the value of pharmacy services would be necessary for these initiatives to be successful for the South Asian population.

A further White Paper *Pharmacy in England: Building on Strengths – delivering the future* was published in April 2008 (DH, 2008b). This set out the Government's programme 'for a 21st century pharmaceutical service and identified practical, achievable ways in which pharmacists and their teams can contribute to improving patient care through delivering personalised pharmaceutical services in the coming years'. The White Paper proposed changes to the current NHS market entry system called 'control of entry' to one based on PCTs' assessments of local needs to commission services, as part of the policy of promoting choice and competition in the delivery of high quality, clinical care. It also contained proposals to enable PCTs to take effective action on quality grounds where contractors were not achieving acceptable performance standards. In October 2009, the Responsible Pharmacist Regulations (2008) came into operation. These enable a registered pharmacy to continue to operate for the sale of General Sales List medicines for a maximum of two hours in a twenty four hour period (midnight to midnight) without the presence of a Responsible Pharmacist, subject to specified conditions. The impetus for these changes is a recognition that development of the pharmacist's clinical role and contribution to improving healthcare services, may be hampered by the inability (under previous legislation) of pharmacists' to be absent from the registered pharmacy premises from time to time. As with the GP contract, recent reforms in community pharmacy encompass multiple and competing goals. For example

policies to encourage pharmacies to provide advice and support appear to assume that this will improve patient adherence to medication regimes and imply that patients have knowledge deficits which can be addressed by advice from pharmacists. Yet this thesis will argue that tensions can exist between pharmacists, GPs and patients in a context where the latter may choose to exercise some degree of strategic non-adherence with prescribed medication regimes to enable them to achieve a balance in their lives and to attain a sense of well-being and control. Some of the literature to support this notion is reviewed in the next chapter. It will also be argued that policies to make community pharmacies more responsive to consumers may render professionals to be more dependent on patients' opinions, which has implications for professional status and may threaten role extension.

### **Summary of Sections 2.2 and 2.3**

Government NHS and community pharmacy policies to reduce the burden to health inequalities are based on modifying lifestyle and behaviours (the 'medical' model) as opposed to considering the structural and economic factors behind ill health and health needs of BME communities. Since completion of initial data collection for this PhD study in 2004, existing methods of delivering NHS healthcare including community pharmacy services have been continually redesigned and reconfigured. Although this was an important milestone for pharmacy, it raises a lot of issues. The questions raised as a result of this appraisal still remain the same as those raised by Turner (1986) in response to the Nuffield report (Committee of Enquiry, 1986). How could community pharmacists, who were always viewed in their more traditional roles as 'dispensers' be able to deliver these radical changes in their services? The research evidence underpinning the policies is questionable. As shown in further reports on health inequalities (DH 2008, DH, 2010), the debate still continues. In relation to this PhD study, the key issues arising from the appraisal of key government policies in relation to the delivery of services to BME, in particular South Asians are:

- Reference to the pharmaceutical health needs of South Asians in the recent pharmacy policies is patchy and an appraisal of research underpinning the policies is needed in order to underpin the key research questions for this PhD study
- Radical operational changes have been proposed for the delivery of Pharmacy policies. They include the need for multi-disciplinary working. Have these

changes been adequately communicated and publicised for GPs and the South Asian service users in Leicester?

- Further appraisal of the research relating to the use of services in the new Pharmacy contract by the South Asian population, particularly in relation to public health, health promotion and the management of minor ailments is needed. In the next chapter, key reports and studies are appraised to understand and further contextualise the main areas of exploration for this study, and to illustrate if the findings can be underpinned by research evidence.

At this point, it is noteworthy to say that many of the key policies and empirical literature reviewed in this chapter include that upto and including the period of data collection for this thesis. It was imperative that further policy and definition changes underpinning this research study upto the time of submission (Jan 2010) were included, as it was essential that the arguments developed from the findings could be better illustrated and aligned to current knowledge.



# Chapter 3

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## Literature review

## **CHAPTER 3. LITERATURE REVIEW**

This chapter reviews published research relating to the access and provision of pharmaceutical services, in particular to members of the South Asian Minority Ethnic population. Selected relevant research within the context of health services provision is also reviewed. This sets the background to the study.

There has been a considerable amount of work published on different aspects of health care for South Asian patients, much of which concentrates on specific illnesses, and in the main the literature remains descriptive. Currently there is a need for more robust data, both qualitative and numerate, to allow informed decisions to be made for the rational provision of health care services for this population within the NHS. The aim of the literature search was to focus on papers that addressed community pharmacy input into care for South Asian minority ethnic populations in the UK. The literature review provides details of the search terms, dates and databases used. It also includes details of reports into community pharmacists' input to the needs of South Asian minority ethnic population groups in general.

**Section 3.1** highlights the strategy for the literature review.

**Section 3.2** appraises the literature

### **Section 3. 1. Literature search strategy**

Literature searches were conducted (repeated) at different stages of the study due to the part-time execution of the study.

#### **Initial review of the published literature (1990-2004)**

Preliminary work for this PhD study commenced in 2000. First phase data collection commenced in 2001 and was completed in 2004. A literature search was initially designed to support the research strategy and updated constantly during the data collection period. During this period, the author chose to review the literature from 1<sup>st</sup> Jan 1990 to 31<sup>st</sup> Dec 2004. This was the earliest date chosen as a thorough literature review of the earlier literature was undertaken in the study by Aston University to support the findings of the study published by Jesson et al (1994a,b; 1995). Earlier papers (prior to 1<sup>st</sup> Jan 1990) were only included if a particular article identified by citation checking added substantively to the review.

At the start of the study, a broad literature search was conducted using the key words illustrated in Table 6. The following databases were searched. Most databases were available from the DMU library portal:

Medline (PUBMED)

CINAHL

International Pharmaceutical Abstracts (IPA)

Pharm-Line

Embase

Psychinfo

Centre for Research in Ethnic Relations database (CRER from the University of Leicester clinical sciences library portal and the University of Warwick library portal)

Cochrane Library

ZETOC

SCOPUS

Web of Knowledge

National electronic library for Health (NELH) (the predecessor of NHS Evidence)

Using facilities such as 'citation alerts (e.g. Zetoc) was a useful tool when certain key articles were cited. This is available for most journal websites (e.g. [www.bmj.com](http://www.bmj.com)) and other online portals such as Science Direct ([www.sciencedirect.com](http://www.sciencedirect.com)).

Hand searches were made from the following:

- Health Education Journal,
- Pharmaceutical Journal
- International Journal of Pharmacy Practice
- Journal of Social and Administrative Pharmacy
- Pharmacy World and Science, Annals of Pharmacotherapy
- British Pharmaceutical Conference abstracts.

For major policies, the Department of Health ([www.minorityhealth.gov.uk](http://www.minorityhealth.gov.uk) accessed Dec 2004) website was searched, as well as registers including the National Research Register Archive (NRR)<sup>7</sup> and the Picker Institute Europe<sup>8</sup>. During the latter stages of this study, the principal investigator also took advantage of other internet search engines including 'GOOGLE SCHOLAR'.

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<sup>7</sup> (<https://portal.nihr.ac.uk/Pages/NRRArchive.aspx> accessed Dec 2002

<sup>8</sup> (<http://www.pickereurope.org/> accessed Dec 2005)

The databases were searched for references using standard procedures including: truncation; Boolean Operators for combining search terms; and searching for phrases using the phrase in quotation marks. Advice on identification and use of the key search terms included consulting the librarians at De Montfort University, the University of Leicester and the librarians and experts based at the Mary Seacole Research Centre, De Montfort University.

**Table 6. Key words for searches of the published literature**

Limit to human and English

Communication Communication barriers Community pharmacy services Pharmacy Pharmacy service, hospital Asian* Sikh Pakistani Bangladeshi Hindu Moslem Ethnic groups Pharmac* Ethni* Pharmaceutical services Medication systems Minor illness Ailments Ailmen* Minor + ailmen* Ethnic adj. groups Indian Cultur*	Health adj. care Healthcare Pharmaceutical care Drug* Drug information Health service(s) Prescription General practice General practitioner(s) Doctor Community health services Ethnicity Ethnic* Health South Asian Ethnic minority Ethnic minorit* Minority ethnic group Health promotion General practice Primary care
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The studies included could not be graded by 'quality' (e.g. CRD taxonomy of study quality or the grading identified) since few met the basic requirements for such an analysis.

The results of this search are illustrated in Table 7. Only studies from the UK were reviewed because of differences that are likely to be found due to the diverse health care systems in operation internationally. Studies and articles appearing in peer reviewed journals and publications, peer reviewed web based databases and

websites were included. There was considerable variation for 'hits' whilst searching the known databases. Examples of the search strategies are illustrated in Appendix 3.

**Table 7. Results of published literature search pertaining to South Asians and pharmacy services in some databases**

Database	Key Search terms in Title and/or abstract of the study	Comments
PubMed (Medline)	'Asian' or 'South Asian' AND 'Pharmacy' or 'community pharmacy' Limit to English, Human studies, in UK, Limit between 1990-2004.	Mainly US studies identified
CINAHL		Mainly nursing based studies, some with 'pharmaceutical' issues
PsychInfo		No studies with pharmacy
Pharm Line		10 studies of which 1 met the criteria (1990-2004)
International Pharmaceutical Abstracts		13 studies of which 2 met the criteria (1990-2004)

It was concluded that there was a paucity of literature that cited/concerned the use of community pharmacy by the South Asian population between 1990 and 2004 when the major databases were searched. The principal investigator had to broaden the search to include searching the 'grey' literature.

### **Searching the 'grey' literature**

'Grey' literature refers to publications issued by government, academia, business, and industry, in both print and electronic formats, but not controlled by commercial publishing interests, and where publishing is not the primary business activity of the organization (Atkinson et al, 2001). The term is often used to describe anything that does not appear in a recognized 'peer reviewed' scientific journal series. Scientific grey literature comprises hundreds of newsletters, reports, working papers, theses, government documents, bulletins, fact sheets, conference proceedings and other publications distributed free, available by subscription, or for sale. Some of these studies can be identified and read, but only a few are developed to a publishable standard so that they could be searched and retrieved through scientific databases.

Many studies are submitted only for academic accreditation and examination which are not readily accessible without knowing who conducted the studies. Similarly, many health and local authority bodies obtain, or set aside, funds for relatively short, fixed term projects that are intended to find ways of meeting (or assessing) the needs of minority communities in their areas. Many such reports are not found in central repositories. Knowledge of libraries such as the Kings Fund library in London<sup>9</sup> and the Centre for Research in Ethnic Relations (CRER)<sup>10</sup> (until 2005) were an invaluable resource for the searches for this project. Presley and Shaw (1995) have published a useful sources guide to obtain such reports. There were no extra research papers cited in the grey literature located which looked at the use of community pharmacy by South Asian minority ethnic populations (beyond the study by Jesson et al (1994b)).

This chapter is therefore not a 'systematic' review of the literature. The process used in the selection of studies was guided by a need to conceptualise and frame the developing research, and was therefore conducted in an iterative manner. It was concluded that the final selection of studies would be better 'grouped' using a more 'contextual' approach. By doing this, key concepts pertaining to the health of South Asian minority ethnic populations could be identified and discussed in relation to community pharmacy policy and practice. Existing academic and theoretical debates in this field were used to develop the main research questions, which are presented at the end of this chapter and further developed in Chapter 4.

### **Final review process**

A pragmatic process was then adopted for selection of papers from the main literature search and the grey literature for inclusion and exclusion in the review (adapted from Atkinson et al, 2001). This was an on-going process during the course of data collection.

An article was considered for inclusion in the review if it:

- provided an abstract (so that a decision could be made on content);
- the abstract contained a substantial reference to 'South Asian' or 'ethnicity' and;
- the abstract contained a substantial reference to access to services and;
- the abstract indicated that the paper might be generalisable / applicable to a UK community pharmacy setting (e.g. if the study was done in a GP setting and the

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<sup>9</sup> <http://www.kingsfund.org.uk/> (accessed Jan 2007)

<sup>10</sup> <http://www2.warwick.ac.uk/fac/soc/crer/> (accessed Jan 2003)

methodology and outcomes could be explored within community pharmacy practice research setting)

- the abstract included research relating to any cultural and professional barriers relating to 'ethnicity'.

Where possible, the criteria outlined in Table 8 (Page 64) were applied.

Because of the large number of papers identified in the 'grey' literature, (2,000 plus), a publication date of December 31<sup>st</sup> 2004 was initially used as the date filter during the initial stages of the study.

A paper was excluded if:

- ethnic minorities or ethnicity were 'mentioned in passing' and not a significant focus
- there was no mention of access and/or (differential) uptake of services
- it was not generalisable /appropriate to UK settings or groups

Hence, the author appraised following areas in this literature review:

- An appraisal of some key national and local reports relating to the health of ethnic minorities in the UK (some of which are also appraised in the previous chapter to set the context for this PhD)
- Health of South Asians and health seeking behaviour patterns of South Asians
- Cultural influences on health seeking behaviour
- Communication and health promotion for the South Asian population
- The use of community pharmacy and General Practitioner services by the South Asian population (including access and potential barriers to use of services)

Key studies underpinning the use of community pharmacy services by the 'white' population in the UK, including the management of minor ailments. This was needed to identify a 'conceptual framework' for this study and its relevance to the South Asian population, but had to be kept within manageable limits. Appendix 1 outlines many of the studies initially appraised to provide a contextual framework for this study. The critical review in the following sections includes these studies as well as key studies and reports post data collection for this thesis.

**Table 8. The ideal criteria used for inclusion of studies and reviews in the literature review.**

Criteria	Comment
Systematic reviews which include at least one randomised controlled trial (RCT) e.g. Cochrane reviews	“Gold standard”
Other systematic and high quality reviews which synthesise references	Often descriptive 'Best Practice'
Individual RCTs	
Individual non-randomised intervention studies Individual well-designed non-experimental studies, controlled statistically if appropriate. Includes studies using case control, longitudinal cohort, matched pairs or cross-sectional random sample methodologies, plus well designed qualitative studies and well-designed analytical studies including secondary analysis	Potential basis for further research
Descriptive and other research and evaluation (not cited above)	Potential sources of Good Practice
Case studies and examples of good practice Summary review articles and discussions of relevant literature and conference proceedings not otherwise classified	

### **Update of literature review 2005-2010**

The study was interrupted in early 2005. When the study recommenced in 2007, and immediately before completion, the principal investigator repeated the literature search strategy to retrieve and review further relevant work done in the study area. The search strategy for this included reviewing the key literature between Jan 2005 and March 2010. Many of these reports and references are also included and cited in the discussion chapter later in the thesis. Where appropriate, the salient points and recommendations from these reports have been used to illustrate the relevance and 'currentness' of some findings from this PhD study.



## **SECTION 3. 2. APPRAISAL OF THE LITERATURE**

In Chapter 2 the principal investigator highlighted strategic national policies where the Government declared its aim that the public should be offered a choice of good quality services that are sensitive and responsive to the needs of the patient.

This PhD study concentrates on how community pharmacy services are used by the South Asian ethnic minorities. However, it is imperative to emphasise that an understanding of how the indigenous 'white' population perceives community pharmacy services should also be considered. The policies highlighted in Chapter 2 are assumed naturally to base recommendations on 'firm' evidence of the current role community of pharmacy services and that the changes envisaged to these services were also based on good evidence. Therefore reviewing some of the literature on how the white population uses community pharmacies can be used as an 'obvious' choice for comparisons to the South Asian population. Much of this literature included in this chapter was also appraised prior to data collection (for contextualising the study-see Appendix 1), as data was being collected for the study, and in the period beyond data analysis.

The literature is appraised as a 'thematic' approach under the following areas:

**Section 3.2.1** The use of community pharmacy services by the South Asian population

**Section 3.2.2** Key studies underpinning the perceptions of community pharmacy services by the 'white' population in the UK (with emphasis on access and the management of minor ailments). This was needed to identify a 'conceptual framework' for this study and its relevance to the South Asian population

**Section 3.2.3** The use of General Practitioner services by the South Asian population (with emphasis on access and the management of minor ailments)

**Section 3.2.4** Appraisal of key reports on the health of BME population in the UK (some of which are reported in the previous chapter to set the context for this PhD)

**Section 3.2.5** Cultural influences on health seeking behaviour of South Asians

**Section 3.2.6** Communication and health promotion for the South Asian population

**Section 3.2.7** Professional collaboration

### **Section 3.2.1 The use of community pharmacy services by the South Asian population**

For pharmacists to have an appreciable role in providing an information service for BME groups, it was important to have an understanding of these issues, particularly what was happening at local level. From the wider review of the literature, the author of this study accepted that there were problems associated with the way in which health care services are provided for such groups. However, very little had been published concerning the interface between pharmaceutical services and these groups, and much of the published work was anecdotal in nature. However, such studies as do exist are highlighted below

Wiggins (1990) carried out a survey to assess patients', practitioners' and pharmacists' viewpoints on the provision of healthcare services, particularly pharmaceutical services for Asian communities in East London (n=28). The reported analysis technique mentions 'quantitative methodology' and relies heavily on anecdotal information. The main results of the study were published as a result of patients' interviews which elicited direct information. The methodology and results of the interviews with GPs and pharmacists were not clarified or commented on other than that the results 'yielded many personal experiences and opinions of both the needs of minority ethnic groups and the present state of pharmaceutical services'. Several areas for improvement were identified including the use of plain English when labelling medication, and the translation of Patient Information Leaflets into Asian languages. This was a small study with little evidence of the research methodology, but suggests that a qualitative research approach could be used to get more meaningful insights into communication and health promotion strategies.

Jesson et al (1994b, 1995) explored the needs, perceptions and use of pharmacy services by ethnic minority communities in an inner city setting. The researchers specifically set out to examine whether ethnic minority communities were actually accessing the full range of community pharmaceutical services, what barriers might exist and how these might be overcome. The results were compared to those from a general 'baseline' of a mainly white sample representative of the West Midlands region as a whole (Jepson et al, 1991). A sample of people of black Caribbean, and sub-continent Asian (South Asian) origin was chosen. The South Asian sample was further divided into Muslim, Sikh and Hindu sub-samples. An interview schedule was used comprising 34 questions including closed and open questions with 'sub' questions. The survey was administered by interviewers who were themselves

members of the selected ethnic minority groups. Interviews were carried out in the respondents' homes. The sample size comprised of 202 people (males=100), consisting 73 (36%) Black-Caribbean and 129 (64%) Asians. Some of the key findings of the study by Jesson et al (1994b) are summarised in Box 5 (page 68). The study also highlights the limitations within the methodology, particularly difficulty in obtaining interviews, identifying an appropriate sample and difficulties in getting people to participate for interviews. It was noted that female Muslim patients preferred to be interviewed by a female interviewer. It was concluded that the use of, and access to, pharmacy services by this minority population appeared to be lower than the majority population, although their needs were probably higher. The authors concluded that pharmacy services were not utilised effectively by the South Asian ethnic population because of both communication problems and how the pharmacist's role is perceived by this particular population. The researchers also emphasized that it is not only communication needs that are important for pharmacists working with the South Asian ethnic minorities, but an overall understanding of the cultural issues surrounding the use of both conventional and traditional Asian medicines and other cultural sensitivities and practices (e.g. the Fast of Ramadan). Key recommendations were made by the authors and this PhD study was explicitly intended to follow up these issues. The findings of this PhD study are compared to the study by Jesson et al (1994b) and illustrated in Chapter 6. It will be shown that the findings of this PhD study triangulate well to the findings of the study by Jesson et al (1994b), and further insights have been shown that enhance the previous findings.

Smaller pharmacy based studies relating to communication needs of South Asians have also been conducted by Abbas et al (1992) and Jessa (1994) are reviewed in section 3.2.6 (page 115).

### **Box 5. The main findings of the study by Jesson et al (1994b)**

The health status of the South Asian respondents: less than one third of the respondents said they were not very healthy. This was twice the self reported rate found in a white 'control' sample done in a previous study (Jepson et al 1991).

One third of the Muslim respondents of the study said they could not read English, and some individuals from other Asian background said that they could understand very little spoken English. More women than men stated they could not write, speak or understand English. Many of the respondents also admitted they were not fluent readers of any other language.

Over half the minority sample used only one pharmacy, and this was lower than the 'white' regional sample. Just over half the minority ethnic sample indicated that there were people from their own ethnic background working in the pharmacy.

Almost 75% of the minority ethnic sample was aware that pharmacists offer advice on how to treat a minor ailment. However, less than half had actually used the advisory service. This was lower than the 'white' sample. When further analysed, the Muslim sample was the least likely to have sought advice. This sample also alluded to believing that it is not the pharmacist's role to give health advice.

Only one third of ethnic minority respondents had noticed leaflets about health related issues in the pharmacy. Only one in six respondents from an ethnic minority background had actually read the leaflets available in the community pharmacy. This is mainly because they had not noticed them.

There was some debate whether translated leaflets would be useful due to poor mother tongue literacy skills. Only 23% of respondents whose first language was not English received verbal translation of medication instructions.

One third of the total minority ethnic sample said they fasted with the highest prevalence in the Muslim sub sample. 'Non-compliance' consisted of dosages being re-adjusted to accommodate the fasting period, and only a few individuals missed out doses of medication all together.

17% of respondents stated they would not take medicines that conflicted with their religious beliefs (e.g. if they had particular constituents) or if they were concerned with side effects. 30% of the respondents used traditional medicines and home remedies.

Travel health: 36% of the sample had visited their country of origin within the last 5 years and only a few had sought health advice or received preventative care from the pharmacist.

Most respondents identified the pharmacist as a dispenser or 'maker' of medicines.

Only 20% of respondents said that the pharmacist was 'an advisor on health', and was also perceived to sell non-medicinal products such as nappies, toiletries etc.

There were mixed perceptions on the use of alternative practitioners such as hakims or vairs (Asian traditional health practitioners).

There was a relatively high interest in certain extended roles of the pharmacist, such as screening and delivery services.

Since the data collection period for this PhD study, studies by Huckerby et al (2006); Howard et al (2007) and Gilani (2007, 2008) have been conducted which describe a pharmaceutical service specifically tailored to a South Asian community. Both studies highlight areas where 'tailored' or 'culturally sensitive' services could yield positive outcomes if well resourced. Howard et al (2007) describe a pilot pharmaceutical service which started in Nov 2005 to offer medicines advice to Bristol's South Asian community. The service was run by two community pharmacists, one male and one female, who were employed by Bristol PCT for one day a week. Both came from South Asian backgrounds. In the first 12 months of the project, the pharmacists saw 154 new clients. A further 76 were invited but did not attend, and 64 people turned down an appointment after discussing it on the telephone. Early results showed that in a sample of 69 clients, main outcomes included: fewer visits to the GP (n=3); a reduction in falls risk (n=1); improved concordance (n=18); better patient knowledge (n=61). On average, each consultation lasted 46 minutes. Gilani (2007) describes a service by which pharmacists could help deliver a 'culturally competent' service to the South Asian community in Scotland, including targeting young people, blood glucose screening in high-risk individuals, advocating more aggressive targets, targeting and educating vulnerable groups in pharmacies and elsewhere, offering medication reviews and independent prescribing. The author elaborates on the benefits of a 'holistic, culturally competent approach' to pharmaceutical care in a minority ethnic patient population. The service described by Gilani has been further developed and continued in Scotland (personal communication May 2010). The South Asian Health Foundation also highlights major research initiatives in South Asian health, although no direct references have been made to the involvement of community pharmacy in major research initiatives (e.g. Khunti et al, 2009).

These studies and initiatives were some of the very few that cited the involvement of pharmacists with South Asian patients, and were hence included in this literature review. However, the pharmacy studies reviewed at the time of data collection for this PhD study included small numbers of patients and reported inadequate methodological considerations for any generalisations to be made, particularly the lack of exploration of sociological factors. But, nevertheless, they did highlight areas for further exploration for this PhD study. The principal investigator widened the literature search to identify further studies which could illuminate potential insights into health seeking behaviour of this population, and these have been reviewed later in this chapter.

### **3.2.2. Key studies underpinning the perceptions of community pharmacy services in the UK**

The literature highlighted in the previous section concentrated on pharmacy studies pertaining to the South Asian populations, and it must be acknowledged that many of these concepts have also been explored in the wider literature addressing the 'white' population. The author of this study considered it prudent to highlight some of the key literature purely to provide an overview so that the reader is able to appreciate that many of the concepts identified for the PhD study pertaining to pharmacy services for the South Asian population were not unique to this population, but stem from studies in the wider population. Due to the large number of studies, a full and comprehensive review of the literature was beyond the scope of this study. However, the author has appraised some key areas such as self care, the management of minor ailments, public perceptions to community pharmacy services, attitudes to pharmaceutical care, medicines concordance (and/or adherence) and the impact of the new pharmacy contract.

#### ***Self care and the management of minor ailments***

For this PhD study, the principal investigator had chosen to explore as one of the objectives, the management of minor ailments by the South Asian population. This stemmed from her observations of consultations for these conditions during her practice experiences in GP surgeries and community pharmacy within the inner city practices of Leicester City. A systematic review of access to health care and ethnicity found no research on access to primary health care for minor illness for different ethnic groups (Atkinson, et al 2001). It was therefore important to review some of the pertinent literature which informed the recommendations made in the White papers (DH, 2000b; DH 2003b) about the community pharmacy management of minor ailments and explore whether these findings could be related to South Asians.

A small qualitative study by Morris, Cantrill et al (1997) determined consumers' views about over-the-counter (OTC) medicine purchases. Qualitative telephone interviews were conducted with 40 consumers recruited via two community pharmacies. Consumers' views and spontaneous comments were obtained regarding their expectations when making their most recent OTC medicine purchase. Their awareness of the need for questioning, and their willingness to answer questions about minor ailments were explored. Although the majority of consumers had a

degree of awareness of why pharmacy staff might require information, 25 consumers expected to make their most recent purchase without being questioned. Consumers' attitudes to unsolicited questioning appeared to be affected by their perception of whether questioning was necessary. In addition, the majority of consumers seemed to view decisions about medicine purchase as their sole responsibility, rather than perceiving pharmacists to have a professional role. The results also suggested a wide variation in the needs and preferences of individual consumers. The study did not mention if South Asian participants were involved. Hassell et al (1998) also explored advice-giving behaviour in community pharmacies in order to understand the nature and process of pharmaceutical consultations and consumers' views of the advice-giving role. An ethnographic research strategy was used, combining patient interviews with non-participant observation of interactions between consumers and pharmacy staff. One week was spent in each of 10 pharmacies. The study demonstrated that the advice given in a community pharmacy is almost wholly focused on product recommendation and use. Advice-giving varies according to whether consultations concern prescription or non-prescription medicines. When the latter are involved, advice-giving is mostly consumer-led. Consumers' major 'need' for pharmacy services appears to be for information about the effectiveness of products they buy, whilst pharmacists and pharmacy assistants concentrate on providing advice on the safety of medicines. The notion of pharmacists as general health advisors does not appear to be shared by the public and may be at odds with how the public view and use pharmacies. Protocols to guide staff may be improved by including the consumer perspective. Most consumers have previous experience of their ailments and use pharmacies as one of several resources available to them to treat their minor illness, having made their own diagnosis and assessment before entering the pharmacy. The scope for giving new advice is therefore limited. The broader role of community pharmacies merits further attention. The NHS Plan, published in July 2000, outlined the vision of a health service designed around the patient. (DH 2000c). The plan emphasised self-care as being key in the modernisation of the NHS. The NHS Plan also aimed to make better use of the skills of NHS staff. In September 2000, *Pharmacy in the Future* (DH, 2000b) highlighted community pharmacists as being well placed to help people cope with everyday health problems. *Pharmacy in the Future* stated that by 2004, every PCT would have schemes in place so that people could get more help from pharmacists in using their medicines. Minor ailment schemes may help to achieve this target, and also assist PCTs achieve several of the objectives for community pharmacy in *A Vision for Pharmacy in the new NHS*. (DH, 2003b). This document states that community

pharmacy should:

- be — and be seen to be — an integral part of the NHS family in providing primary care and community services
- support patients who wish to care for themselves
- be a source of innovation in the delivery of services
- help tackle health inequalities
- be a point of first contact with health care services for people in the community.

Underpinning this recommendation was a major study (Whittington et al (2001a and 2001b), Hassell et al, 2001) which demonstrated that the care of about one third of people who present with a group of minor illnesses could be transferred from a general practice to local community pharmacists with only a minimal increase in re-consultation rates with general practitioners. The researchers achieved this with a combination of measures which included a mechanism for the provision of medicines from a limited formulary by a pharmacist free of charge to the patient. The study population was predominantly 'white' and had no 'control group'. Many PCTs in England were considering implementing or had already piloted similar initiatives on the basis of the recommendations of this study. This study also underpinned the basis of a minor ailments scheme which was advocated in the NHS reforms for community pharmacy services in Scotland. The literature review underpinning the study by Whittington et al (2001a and 2001b) was considered by the author of this PhD study to be robust. The study design was robust and the authors fully endorsed its limitations. There was no mention of South Asians or the ethnic background of participants and hence the results could not be generalised to other population groups. The study was set in Sefton, Merseyside where there is not a significant South Asian population. It involved one general practice site and eight community pharmacies who had good professional links with the practice. The nature of advice given by community pharmacists on the management of the condition was not explored. The minor ailment conditions chosen because they had high presentation rates in the practice, because the GPs in the practice were willing to transfer their management, and because pharmacy medicines were available for their treatment, were subjectively selected and specific to that study. Patterns could be different in areas where there is a significant South Asian population, and these would need to be determined to meet local needs. This was one of the key objectives explored in this PhD study. The findings from this PhD study will argue that that collaboration with GPs and community pharmacists would need to be strengthened if initiatives like



those demonstrated in the study by Whittington et al (2001a and 2001b) were to succeed in Leicester City, particularly where there is a significant minority South Asian population which relies heavily on GP services for advice and treatment options for minor ailments. For this PhD study, the relationship between GPs and community pharmacists was also explored in addition to the views of South Asian service users. Interviews with patients in the study by Whittington et al (2001a) suggest that the community pharmacy referral was used only when patients had a clear understanding of their illness and its treatment. The findings of this PhD thesis illustrate that South Asians desire to be more 're-assured' of their symptoms, particularly coughs and colds, and that a 'diagnosis' by the GP was more important. In addition, the findings will demonstrate that South Asians would like a better 'relationship' with the community pharmacist as a 'healthcare professional' and as such, further development of the community pharmacist's consultation skills and in turn, the 'professional' image would be needed. Other studies have also demonstrated that minor ailment schemes may improve 'access', but that inter-professional relationships between community pharmacists and GPs are also important.

How GPs manage minor ailments is likely to affect how patients perceive and handle similar illnesses in the future. Whilst this potentially has significant implications for general practice workload, research investigating GP' attitudes towards minor ailments and their pharmacists' involvement in the management of this condition beyond that of their current 'supply' role is sparse. Morris, Cantrill et al (2001b) commented that in general, a significant proportion of 'inappropriate' demand for GP services is generated by consultations for minor ailments. The authors conducted a study to describe GP' experiences and perceptions of minor ailment consultations and their attitudes towards minor ailment management. A questionnaire survey was conducted in 1999, derived from a series of 20 qualitative interviews with practising GPs. The survey was sent to one GP randomly selected from each practice (n = 759) in eight English health authorities. Attitudinal statements were analysed using factor analysis. Four hundred and fourteen GPs (54.5%) completed and returned the questionnaire. Respondents were consulted regularly about minor illness or symptoms, with almost all (95.6%) having experienced a minor ailment consultation in the previous week. Factor analysis suggested four issues to be of importance in determining GP' attitudes to minor ailment management. These were attitudes towards pharmacists, attitudes towards patient empowerment, frustration with minor ailment consultations and attitudes towards caution/risk. Although GPs were clearly

frustrated by the level of minor ailment consultations, this study suggested that there may be more complex factors which influence their attitudes. The authors argued that for the optimal management of minor ailments, inter-professional relationships potentially are of great importance, and that with increasing patient demand, it is essential that finite health care resources are accessible, appropriate and used in an optimal way.

Blenkinsopp et al (2002) conducted a comprehensive review of the evidence from operational pilot minor ailment schemes. At the time of the initial literature review of this PhD study (2001-2003), minor ailment schemes were operational in nine PCTs in England and two Health boards in Scotland. At least 10 other PCTs in England were in the planning stage. The review considered the benefits and drawbacks of the schemes, and was used to support discussions on wider roll out. This review did not consider patient experiences of such schemes and mainly considered the schemes' impact on pharmacy and GP workload, PCT workload, access and prescribing costs in the main. The NHS Improvement Plan stated that the Department of Health advocated minor ailment schemes. (DH, 2004a). Similar initiatives had also been rolled out and evaluated in Scotland (Schafheutle et al, 2003). The papers emphasised that there were variations in how community pharmacy management of minor ailments was perceived by general practitioners. Jesson et al (1994b) had already shown that South Asians did not visit the pharmacist as a first port of call, and the wider literature in this population confirms that South Asians consult GPs more frequently for minor ailments than the white population. These studies further endorsed the need for consultation patterns for minor ailments to be explored further with this population. Parmentier et al (2004) reported results of a similar scheme done with refugees in South London. The study clearly demonstrated the feasibility of such a service for populations whose first language may not be English. A briefing (National Prescribing Centre, 2004) highlighted the evidence base behind this initiative. It must be emphasised that local evaluations of such schemes were sparse and many were not available for review at the time of the initial literature search. It was clear that there was not much evidence of the outcomes of such initiatives apart from a perceived improvement in access to general practitioners, and more importantly, the acceptability of such schemes for enhancing the health advisor role of the community pharmacist. The study by Whittington et al (2001b) stipulated that patients accepted the 'ethos' of the scheme provided they were aware of their condition and they were reasonably informed of their options. The author of this PhD study considered all the evidence and, together from her experiences in practice,

considered it prudent to further explore the views of the local South Asian population and stakeholders about these initiatives for local implementation in Leicester City.

Hammond et al (2004) have demonstrated that despite pharmacists having increased involvement in managing minor illness, many patients continue to attend their GP with problems that could be managed by community pharmacists. Their study investigated the prevalence of visits to the GP that GPs felt could be managed by a pharmacist, and to explore patients' reasons for such visits. This cross-sectional questionnaire study was conducted at 13 general practices in West Sussex, UK. A questionnaire was given to all patients attending appointments with their GP in these practices over a 1-week period, asking what the presenting problem was and whether the advice of a pharmacist had been sought. If patients had not sought the advice of a pharmacist, they were asked why not. The GP was then asked to indicate whether, in their opinion, the patient's problem could have been managed by a community pharmacist. The response rate was 94% (3984), representing 87% of all patients consulting their doctor during the week of the study. GPs felt that only 7% (260) of these visits could have been managed by a community pharmacist. The proportion of 'unnecessary' visits was significantly higher ( $P \leq 0.001$ ) amongst young adults, those presenting with new medical problems and those consulting about a child's health. Skin and musculoskeletal problems were the most common causes of 'unnecessary' visits to the GP. The majority of patients making 'unnecessary' visits (59%) disagreed with the GP and felt that the pharmacist would not have been appropriate for their problem. The authors concluded that GPs and patients were, on the whole, in agreement over which conditions were appropriate for GP attention. There is, however, a need for education to increase awareness of the roles of pharmacists, aimed particularly at young adults and at those with children.

The Department of Health is, to date, still deliberating on the wider roll out of a minor ailments scheme for England, as shown in a recent assessment of the service. (DH, 2008a). A study by Puntong et al (2008) showed that although the minor ailments scheme (introduced in Nottingham) was well received by community pharmacists, issues such as lack of privacy, the added burden of paperwork and the restrictiveness of the protocols of the scheme were potential barriers to the success of the scheme. Other studies with 'white' populations have also shown the need for private consultation areas in community pharmacies, and some services requiring private consultation areas such as emergency hormonal contraception have been successfully evaluated in the 'white' population (Anderson and Bissell (2004a).

However, another qualitative study by the same authors illustrates concerns of users of the scheme, and the issue of ethnicity and acceptability to ethnic users of the scheme would need to be further explored (Bissell and Anderson, 2003a). The findings of this PhD study, which was conducted before these studies were published, illustrates similar arguments and socio-psychological issues underlying these concerns.

As illustrated in Chapter 2, community pharmacy services include the provision of appropriate advice to encourage patients to engage better in self care (an essential pharmacy service in the New Pharmacy Contract). The findings of recent studies will illustrate that the arguments put forward in this thesis are still valid. In 2005, the Department of Health commissioned MORI to conduct a survey of the English public to establish a baseline of public attitudes towards self care and their self care behaviours. The recommendations (DH, 2008d) stated that ethnic minority groups needed particular attention to do enhanced self care – while tending to be of poorer health, they were less active in self care and less confident in their knowledge and understanding of how to self care. The survey data also indicated that only some specific changes have occurred between 2004-05 and 2007 in the self care behaviours and views of the general public, indicating that it would take longer for the full impact of recent policies and programmes supporting self care to be realised. More recently, the Proprietary Association of Great Britain (PAGB, 2009) published a study showing the attitudes and behaviour of consumers, patients, GPs, nurses and pharmacists to the drivers and barriers for self care of minor ailments. The study by the PAGB (2009) did not illustrate breakdown of participant demographics by ethnicity, and used both qualitative and quantitative methodologies. One of the main recommendations includes better knowledge for members of the public about self management and asking the pharmacist for advice, and findings that GPs and nurses have less confidence in the pharmacist and that pharmacists spend little time out of the dispensary (back room). The findings of this PhD study, which was conducted 6 years prior to this report, also illustrate similar observations, confounded by the fact that South Asian participants were encouraging about the widening role for community pharmacists.

The findings of this PhD study will illustrate that the value of 'lay networks' and community engagement, particularly for understanding how such communities perceive medicines and health was an important consideration. These findings add further value to the research evidence provided in a Department of Health report

(DH2007b) which includes summary tables covering different types of self care support interventions that have the potential to benefit the patients and the public as well as the care system. Many, if not most, of the self care support approaches mentioned in the report have the potential to help build social capital in communities by informing, skilling, equipping and empowering people in the most effective way. The studies explored in the review, however, do not give any explicit theory as to why such approaches worked. The authors of the review acknowledged that it was beyond the scope of the paper to examine the various theoretical models that could help explain *why*, though if it was known why certain methods work for certain groups of people, one could tailor self care support in a way as to produce the best outcomes especially for patients. The authors agreed that a number of sociological and psychological theories were needed to explain the range of effects that the various self care support interventions seem to produce, but one idea that lies behind many of the interventions is the formation of “primary groups” (such as community networks, peer groups, social support etc) as an outcome of specific interventions which then seem to produce varied beneficial effects for the individual. The review also highlighted that a large number of the interventions that provide support for self care, even if their primary aim is not to create social networks, ended up with the formation of such groups. For example, the self care skills training courses, education programmes, problem solving and action planning sessions, or the imagery, relaxation, exercise and walking sessions are carried out in groups, and consequently participants in these programmes form informal (in some cases formal) associations, continue to stay in touch with each other and receive support from others as well as actively provide support to others. Self care support networks of this type seemed to be some of the most sustainable outcomes of self care support initiatives which in turn contributed to healthier and more active communities. Another idea that appeared to explain differences in outcomes for different interventions could be described from the literature as process of adaptation, in this case adaptation to social models of care and adaptation to the environment that the social interventions in turn create. It maybe suggested at this stage that these reports allude to the value of the ‘lay referral networks’ (Friedson (1970) and described in Chapter 2 (page 27). Such suggestions and inferences add value to the findings of this PhD study. The findings of this PhD study further endorse these themes, and the possible benefits of social marketing for community pharmacy services have been debated in more recent reports (Jesson, 2007). The findings of this PhD study will also illustrate that ‘social marketing of community pharmacy services pertaining to public health and services in order to enable community pharmacists and their staff to engage better

with the South Asian population.

### ***Public and professional attitudes to community pharmacy services***

Hargie et al (1992) reported results of a College of Health survey of 261 members of the public; the survey looked at consumer opinions of and reactions to community pharmacy services using a communication audit approach that involved obtaining consumers' views on communication with pharmacists and how it could be improved. The survey revealed that loyalty to a particular pharmacy increased with increasing patient age. However, over two-thirds of consumers would go first to their doctor for advice on health problems. The majority would like to see pharmacists being health-oriented rather than business-oriented, yet one-third felt they were primarily business people at present. In terms of interpersonal contact with pharmacists, 56% of the sample felt comfortable about asking pharmacists for advice, although an additional 30% wished this to be the standard of practice. The survey also indicated that customers would like to have more direct involvement from the pharmacist when purchasing over-the-counter as well as dispensed medication.

A survey by Williamson et al (1992) was conducted in England to determine the acceptability of an extended role for community pharmacy. The research included data collected from 133 active elderly people, mothers of young children, carers of people with disabilities, and people employed full time. The results indicated considerable support for the development of new community pharmacy services. The majority of respondents supported the provision of more information on prescribed medicines, opportunity to discuss minor symptoms with the pharmacist, medicine delivery services, and the holding of patient medication records. There was less support for discussing health promotion with the pharmacist and cost was found to be a major obstacle to the acceptability of diagnostic testing. The elderly found all aspects of the extended role less acceptable than did other respondents. It was concluded that there is a need to market new community pharmacy services to more specific population groups. The profession and practice of pharmacy began to change significantly after the recommendations in the Government White paper '*Primary care delivering the future*' (DH, 1996) when in September 1996, the Royal Pharmaceutical Society of Great Britain (RPSGB) published *New Horizons* (RPSGB, 1996), a summary of the largest ever consultation on the future of the pharmacy profession. It gave a summary of the views of more than 5000 pharmacists. Health promotion was ranked second, after advice to patients, as the most important new or expanded service for patients that pharmacists could be providing. '*Building the*

*future'* (RPSGB, 1997) the RPSGB's response to New Horizons stated that pharmacists helped people to maintain good health by providing health screening, advice on healthy living and other services. It acknowledged that both ill and well people visited community pharmacies and that pharmacists are thus 'uniquely placed to offer health information and advice'. The report also acknowledged that the role of pharmacists within health promotion could generally be better integrated with other national and local activities and could be specifically supported by the NHS. The report suggested that in future pharmacists would be in demand by other healthcare professionals, the community pharmacy premises could be used as centres for health advice sessions, and that pharmacists could also provide advice sessions in other health care settings.

In a literature review conducted by Tully et al (1997) the authors reviewed **published** evidence on the information provided with prescribed and purchased medicines by pharmacists and pharmacy assistants; clients' expectations of advice about medicines from community pharmacies and their experience and use of it; and appropriateness and rigor of study methods used. Papers published between 1980 and 1995 inclusively were reviewed and those that were selected reported research findings on any aspect of medicines-related communications and the provision of advice about medicines to members of the public who visited pharmacies in the UK. Forty-two suitable studies were identified and reviewed. There were only a small number of studies available. The lack of consistency in the design of studies meant that a subjective assessment was conducted rather than a criteria-based objective review. Results of the review showed that no common definition of 'advice' had emerged. Most studies reported were quantitative in nature, concentrating on the frequency of advice-giving in community pharmacies and only one study considered the impact of advice on outcome. The quality of advice given was judged highly variable, although pharmacists' referrals, where made, were considered appropriate. Given that pharmacy assistants appear to make most of the medicine sales, very few studies addressed their contribution to advice-giving. The review can provide little insight into what determines when advice is provided, but it does illuminate the disparity between the advice that clients say they want and what they actually seek. Where there appears to be a consensus that advice-giving in community pharmacies is wanted, this review reveals a lack of shared understanding between consumer bodies and the pharmacy profession about who needs advice and when and how it should be given. The need for unsolicited advice-giving associated with the sale of medicines is particularly contentious. With the current programme of 'deregulation' of

medicines, the authors comment that this is an increasingly important issue to resolve. A need for a consensus-building forum to generate guidelines that meet shared expectations between clients, community pharmacists, government and the pharmaceutical industry is suggested.

A major study by Hassel et al (2000b) demonstrated that a conceptual framework was needed to understand pharmacy utilization. This major study included data drawn from an observation study (Hassell et al, 1996), and an extensive literature search linked with an interview study (Hassell et al, 1998). The literature review had also been separately published (Hassell et al, 1999). This major study provided an analysis of a range of pharmacy practice, health services and sociological literature relevant to understanding how the public in UK use and view community pharmacies as a primary health care resource. The literature between 1980 and 1997 was appraised. Combined with exploratory studies using observation techniques, using household diaries and in depth interviews, this study demonstrated that there were many factors that needed to be considered when doing research on utilization of community pharmacy services. The authors demonstrated that the framework for studying this should include the exploration of the following:

- Patterns of use of community pharmacy services, including clinical and socio-demographic factors associated with utilization
- Factors that influenced the process of help-seeking behavior from community pharmacy, including the perceptions of the professional roles of pharmacists particularly by GPs; exploration of the use of OTC medication; reasons why service users opted for self care and when a community pharmacist was consulted for minor ailments; the influence of networks such as local communities and family support; organizational factors (e.g. GP appointment systems, privacy in the pharmacy); access factors (e.g. convenience of location of pharmacy) and economic influences (cost barriers).

A summary of the main recommendations is illustrated in Box 6.



**Box 6. A summary of the findings from the study by Hassell et al (2000b)**

The challenge for community pharmacy is to be able to respond flexibly by widening access and building on the positive aspects that people identify with community pharmacy. They include:

Ease of access - no appointments are necessary, and care can be sought on behalf of other people

Friendly, relaxed, approachable service, where pharmacy staff can spend more time with customers

The pharmacist's profile is that of a drug expert - advising on medicines and prevention of ill health

**Responding flexibly to these positive attributes, the profession should perhaps consider ways to:**

Develop an understanding of what people already know and do about minor ailments so that the profession can build a strategy around that

Become a resource for people who cannot afford non-prescription medicines. There is a need for financial barriers around 'free dispensing' to be removed - this might reduce out of hours calls to GPs, as well as reducing the number of visits people make to general practice for the treatment of common ailments

Consider developing or giving a higher profile to 'out-of-hours' services - may be useful to consider developing help lines, or other technology-based advice services

Consider the issue of 'graduated access', with pharmacies being profiled as a resource and a source of encouragement about self-care action, or as an option to consider rather than going to the GP first.

This study specifically indicated that members of the public did use community pharmacies for advice about medicines and minor ailments, but that the factors mentioned above could also influence this particular behaviour. However, evidence about the extent to which they are used for general health advice suggested that it is not widely used. Similarly, the available evidence suggested that the public infrequently sought pharmacy care as an alternative to the GP. A summary of the main recommendations of this study included the importance of pharmacists to respond flexibly by widening access and building on the positive aspects of community pharmacy services identified in the literature. The authors did mention that the use of the pharmacy was low by ethnic minority groups and they were unlikely to use a pharmacy to purchase OTC medicines or ask for advice. The authors relied on reference to the study by Jesson et al (1994b and 1995) indicating that the South Asian population might be perceived to be 'low' users of community pharmacy services. This review also illustrated that rich data could be obtained from

qualitative exploratory methodologies and that exploring underlying sociological factors with service users could be used to complement or inform further descriptive studies in this field. More specifically, the methodologies and outcomes were considered for this PhD study as it was important for the principal investigator to understand if the conclusions of these studies could also be related to the South Asian population. In contrast, using quantitative rather than qualitative methodology, a larger survey in Northern Ireland by Bell et al (2000) investigated the perceptions of 1000 members of the general public toward current activities and future roles of community pharmacists. The majority of participants (73.2%) visited a community pharmacy at least once per month and 76.7% of respondents perceived pharmacists as caring health care professionals, but most of these perceptions were related to advice and safety of prescription medicines. Over 80% of participants were in favour of pharmacists extending the range of services provided and almost 30% would like to see pharmacists offering more advice on minor ailments. The findings of this PhD study will illustrate that the recommendations of the study by Hassell et al (2000b) have been further explored, and that removing the 'financial' barrier of purchasing OTC medication may only 'divert' South Asian service users to use community pharmacists to obtain such medicines free of charge. This aspect has been discussed in the wider literature (see below). The author of this thesis will argue that the community pharmacists are still regarded as 'shopkeepers' and that the South Asian population would not only require flexibility in the services to widen access, but that a 'trusting' relationship between the community pharmacist and service user encompassing 'cultural' sensitivities would need to be established.

A study by Abu-Somar et al (2000) explored the existence and nature of the pharmacist-customer relationship. Semi-structured interviews were conducted with 20 customers recruited from pharmacy A, a multiple chain pharmacy in a more affluent area, and pharmacy B, a small chain pharmacy. Customers' views differed between these 2 pharmacies. Pharmacy B customers had a personal relationship with the pharmacist and used the pharmacy as a health care resource, while pharmacy A customers did not have a personal relationship with the pharmacist and used the pharmacy for medicine supply. Both groups described disadvantages of multiple chain pharmacies. While most customers viewed pharmacists as drug experts and considered managing minor ailments to be part of their job, they were less supportive of a more extended role in the therapeutic monitoring of drug therapy. The study involved a small sample of patients and the conclusions cannot be generalised. However, the principal investigator of this PhD

study carefully considered the sample and noted that there could be a variation between pharmacists who practiced in a large multiple to that working in an 'independent'. The differences in the 'attitudes' of pharmacists working in 'independent' and 'multiple' pharmacy environment is still an issue of considerable debate (Rogers et al 1998), as it has been argued that pharmacists working for 'multiples' and 'independents' provided different types of services. A report by Hassell (2004) shows that a significantly higher percentage of community pharmacists in the Leicestershire, Northampton and Rutland region are of South Asian origin and work in community pharmacy, and it was pertinent to explore if there were differences in the attitudes and opinions of 'white' pharmacists and 'South Asian' pharmacists in Leicester City and any local variations in service delivery based on their population demographics. For this PhD study, this was considered important, as most independent pharmacists interviewed were of South Asian origin and either employers of independents owned by South Asians or owners of a 'business'.

Access to medicines and cost barriers had been highlighted in many studies in the 'white' population, including studies by Hassell et al (1999, 2000b), Bero and Bond (2001), Schafheutle et al (2002) and Boardman et al (2005). These studies illustrated that the management behaviour of those participants who had to pay for their prescriptions, particularly those from less-affluent or deprived backgrounds, was influenced by cost. Schafheutle et al (2002) explored how charges for medicines incurred by patients influence their decisions for managing acute or chronic conditions, and whether prescription cost and affordability issues are discussed in the GP-patient encounter. People suffering from dyspepsia, hay fever or hypertension, or those taking hormone replacement therapy, were recruited through three community pharmacies in the North-west of England. Six focus groups were conducted with a total of 31 participants, the majority of whom were non-exempt from prescription charges. The management behaviour of those participants who had to pay for their prescriptions, particularly those from less-affluent or deprived backgrounds, was influenced by cost. However, cost was not the overriding influence, with other factors, such as symptom or disease severity, effectiveness, or necessity of treatment, playing a more important part in participants' management decisions. Cost as an issue was reflected in the various strategies used by participants to reduce medication cost, such as not having some prescribed items dispensed, taking a smaller dose or buying a cheaper over-the-counter product. Despite the use of numerous strategies, participants did not talk to their GPs about issues of cost and

affordability. Participants felt that paying for prescriptions was their problem. There was a belief that discussing cost issues could jeopardize the doctor-patient relationship. Although not the dominant factor, medication cost nevertheless influenced participants when deciding how to manage their condition. Awareness of the existence of prepayment certificates, which can be bought by patients who require regular medication, was low, and the authors of the study highlight that this should be addressed through improved information/dissemination. The authors concluded that despite the high level of prescription items exempt, the current level of the prescription charge is still a barrier to obtaining prescription medicines under the National Health Service to those on lower incomes. In the author's opinion, this aspect warranted further exploration for the South Asian community, as the barrier of the NHS prescription charge could be a factor that influenced health seeking behavior and also the necessity of obtaining a prescription for medicines that could otherwise be bought from a community pharmacy.

#### ***Attitudes to pharmaceutical care, medicines concordance and adherence***

In a paper by Hibbert and Bissell (2002), the authors put forward an interesting psycho-sociological perspective on the professional role and status of the community pharmacist in the context of 'consumerist healthcare'. The paper highlights the 'sociological' understanding behind the 'professional' image of the community pharmacist. An interesting conceptual analysis describes how pharmacists act to 'transform' *natural* objects (drugs) into more valued *social* objects (medicines). The authors consider this process as it applies to the everyday and 'taken-for-granted' act of buying medicines in the pharmacy. The methodology draws on focus group and interview data from a study involving consumers and pharmacy staff in the North West of England. The consumers had purchased one of a group of 'deregulated' medicines, which were previously available only with a doctor's prescription. One way in which pharmacists have sought to develop their professional role is by trying to 'formalise' their involvement in the surveillance of medicine sales. The study shows how this 'professionalising strategy' is challenged by the consumer's power in the commercial transaction and their perceived expertise in the management of minor illness. This challenge forms a boundary to the pharmacists' 'transformatory' work, and forms part of an ongoing negotiation of the meaning and relevance of their expertise. The results illustrate the strategies adopted by consumers and pharmacy staff to (respectively) obtain the desired medicines and fulfil professional responsibilities against a background of differing and contested assessments of the risks associated with medicines use. The outcome of the study illustrates that a

'supermarket' style consumerism may still be prevalent, that more and more consumers are becoming 'experts' in using 'medicines' which could be bought without the need for pharmacist intervention. The findings of this PhD study, however, show a slightly different perspective, and that some South Asian participants view certain medicines, including over the counter medicines as 'inferior' or 'cheap' which could affect or even compromise medicines adherence. Indeed, South Asians may not regard pharmacists as undertaking the 'transformation' role identified by Hibbert & Bissell (2002), by considering them only as sales people who provide medicines, and that 'professional' advice should be formalised by the general practitioner.

In the United States Hepler and Strand (1990) proposed a system of 'pharmaceutical care'. In this system, while doctors continue to take ultimate care of patients, pharmacists are responsible for moderating their drug care. In doing so pharmacists co-operate with doctors, patients and carers in designing, implementing and monitoring a 'pharmaceutical care plan' (PCP). By involving patients in decision-making, pharmaceutical care aims to improve communication, promote compliance and concordance with treatment, and achieve specified therapeutic outcomes. Pharmaceutical care has caused considerable attention in the pharmacy literature, because this concept alters the traditional concepts of care and services that pharmacists provide to the public. In the pharmaceutical care concept, pharmacists must ultimately accept their responsibility not only to dispense drugs but also to identify, correct and prevent drug-related problems. The 'pharmaceutical care' model has been adopted in the UK and represents a significant transition for pharmacy, where now the primary focus is the patient and outcomes of care rather than the distribution of medicines. Hepler and Strand (1990) also introduced the concept that an empathetic and trusting relationship between pharmacists and patients is an integral component of pharmaceutical care. In the secondary care sector pharmaceutical care concepts and practices have developed and become embedded as mainstream, but the development of such services in the primary care sector has not occurred at the same pace because of a remuneration structure for community pharmacy which, to this day, largely depends on the speed and accuracy of dispensing a prescription. However, the basic concepts of the pharmaceutical care model underpin the Medicines Use Review (MUR) in the new Pharmacy contract for community pharmacy. Medicines use reviews by community pharmacists aim to help people to use their medicines more effectively. Specifically, the aims are to improve patient knowledge, concordance and use of medicines. It is acknowledged that the

traditional model of medicines 'compliance' (a 'clinical' concept) does not value patients beliefs, concerns and preferences about medicines. The 'concordance' model, a new 'pharmacy' approach to the process of prescribing and medicine-taking, was originally conceived and has most commonly been used to define a process of prescribing and medicine-taking based on partnership. Concordance is defined by Marinker et al (1997) as *"agreement between the patient and the health care professional, reached after negotiation, that respects the beliefs and wishes of the patient in determining whether, when and how their medicine is taken, and the primacy of the patient's decision [is recognised]."* Two way communication was considered to be important in this model (Makoul et al, 1995; Marinker et al, 1997; Maguire and Pitceathly, 2002; Stevenson et al, 2004). In a concordant consultation the patient and the health care professional participate as partners to reach an agreement on when, how and why to use medicines, drawing on the expertise of the health care professional as well as the experiences, beliefs and wishes of the patient. A systematic review by Stevenson et al (2004) examined studies on two-way communication between patients and health practitioners about medicines in order to determine the extent to which concordance was, or was not, being put into practice. The review highlighted that there was little research which examined fundamental issues for concordance such as whether an exchange of views took place. It is possible that more refined interventions and consultation skills were needed to facilitate the development of concordance in pharmacy practice. The findings of this PhD study will illustrate that pharmacists will need to be more 'open' in their approach to MURs in order to ascertain adherence (or lack of) and the reasons for this.

The term 'concordance' has been superseded by 'adherence' (Horne et al, 2005, NICE, 2009). Horne et al (2005) illustrate that the main development in adherence-related research over the past decade has been an increasing recognition of the importance of patients 'common-sense' beliefs about their illness and treatment as determinants of adherence. Nevertheless, the NICE guideline (NICE, 2009) illustrates that there remains a limited volume of research into the 'adherence' or 'concordance' behaviour of minority ethnic groups. The research shows that, although non-adherence may be puzzling or frustrating from the prescribers' perspective, viewed from the patient's perspective it often represents a logical response to the illness and treatment in terms of their own perceptions, experiences and priorities, including concerns about side effects and other unwelcome effects of medicines. Patients therefore seek to balance perceived necessity and concerns and

to minimise their use of prescribed medicines. Studies by Barber et al (2004) and Clifford et al (2006) further illustrated that medicines adherence, particularly with newly prescribed medicines can be improved with better interaction between the patient (client, consumer) and community pharmacist. This would be even more of an issue if communication with the South Asian population was impaired, and it was important to have explored such issues or models in the South Asian population for this PhD study. In addition, it was also prudent to explore any literature related to 'cultural' influences on health beliefs, alongside the pharmaceutical care concept, patients' behavioural patterns and the impact of other influences such as access to relevant information and cost of medication. Some of these studies have been reviewed later in this chapter (Section 3.2.5 page 104.)

### ***The impact of the new pharmacy contract***

Blenkinsopp et al (2003) highlight that the pharmacy's contact with both the healthy and the sick allows it a unique role in early diagnosis and identification of disease. Public use of community pharmacies is almost universal, and although use is currently low for general health advice, it is higher among women, respondents with young children and lower socio-economic groups. This review concurred with the some of the findings by Jesson et al (1994b). A thorough and comprehensive systematic literature review of community pharmacy services was undertaken by Bond (2003). The review commented that there was little research into managerial aspects of pharmacy, and that where this had been addressed it had been interpreted as business orientation and that a multi-disciplinary approach to managed health care should be further explored. The community pharmacy contractual framework (CPCF) for England and Wales was introduced in April 2005. The contract has been evaluated and results have been published (Bond, Blenkinsopp et al, 2007). The researchers collected data from 1,081 community pharmacists, as well as from patients, GPs, and the NHS (at primary care organisation and strategic health authority levels), focusing on 31 primary care organisations in England and Wales. Substantial changes have occurred since the introduction of CPCF. Implementation of essential services is well advanced or complete in most pharmacies. The majority (three quarters) of pharmacies had a private consultation area. Sixty per cent of pharmacies were providing the Medicines Use Review service and over 80% of those who are not; plan to do so in the future. Enhanced services were being provided by 87% of pharmacies, with over 40% providing three or more services. Almost one third of pharmacists report that they are less satisfied with their job and a quarter say they are less likely to stay in community pharmacy than they

were prior to CPCF. Perceived positive aspects of the contract for community pharmacists included increased patient contact and improved relationships with patients. Negative aspects included additional workload arising from the contract, particularly the new requirements for recording data. Lowest satisfaction was related to their role since the introduction of CPCF, remuneration and with respect received from GPs. Many community pharmacists report feeling stressed in relation to their daily work. There is also a need for investment in local change management, more information for patients about the new services, increased patient and public involvement, the development of local pharmacy leadership, and a more proactive approach by community pharmacists to meet with local GPs. While most of those involved in the evaluation thought the contract had the potential to increase integration into primary care, in practice it has had little effect on inter-professional working between pharmacists and GPs. Over 80 per cent of pharmacists said there had been no change in their contact with GPs since the new contract. The findings of this PhD thesis have identified that there would need to be more 'flexible' ways of providing essential and extended services in the new contract, and that South Asian service users want a more 'culturally responsive' service over and above that of a 'universal' biomedical model. Themes such as lack of information through non-sharing of medical records and the apparent non-collaboration with GPs still appear to be prevalent and concur with the findings of this study. More specific findings in relation to the views of the South Asians of this PhD study and the terms of the New Pharmacy Contract are discussed in Chapter 6 of this thesis. In addition, the findings of this PhD study concur with the review conducted on behalf of the Department of Health by the Central Office for Information (COI) (DH 2008d) to support the Pharmacy White paper. The study had two arms; a quantitative arm and qualitative arm and explored the factors that influence the public's use of community pharmacy services. A representative sample of 1645 adults was interviewed in approximately 120 locations throughout England. The sample was selected using a random location method. The following is an excerpt from this report:

*"Overall, the freedom of the pharmacist to issue prescription drugs for minor conditions, to provide certain tests and to dispense repeat prescriptions on his own account within limits, was felt desirable but it raised the difficult issue of access to medical records. The key condition for many, in particular with prescriptions, was that the pharmacist should have access to medical records so that such prescriptions could be safely administered and recorded, and there*



would be information transfer between the doctor and the pharmacist. This was seen as a lesser evil than the risk of medicines being given and doctors not knowing about them, or contra-indications not being picked up. However, others in the sample were concerned about private information such as medical records being accessible to anyone other than the doctor e.g. Saturday assistants and even pharmacists. Although there is interest in the pharmacist offering more services and a sense that the general public are being encouraged to use the pharmacist more, this does raise concerns that pharmacists may become overloaded and thus easy access to help will be lost. Some concerns are raised about training and specialisms, particularly in small pharmacies. The pharmacists largely echoed the consumer sample's views, although some had concerns about the impact on their relationship with local GP's, which had in some instances been difficult. Our very small sample welcomed the idea of providing more advice, tests, and minor medicines and agreed there was consumer demand for these moves. Overall, there was a sense that raising the profile of and knowledge about pharmacists is important particularly so that there is wider understanding of what pharmacists are trained and able to do. Schemes such as the Minor Ailment Scheme felt important in helping to do this. The availability of information in the pharmacy, the doctors' surgery and in the local paper emerged as ways of reaching the general public." (COI on behalf of the DH (2008d, (pages 20-21)).

The conclusions of that report illustrate that despite the radical changes proposed in the 'reformation' of pharmacy services, members of the public have not significantly changed the way they utilise community pharmacy services, a view that will be central to the findings of this PhD study conducted 5 years prior to this report.

### **Section 3.2.3. The use of General Practitioner services by the South Asian population**

It is apparent from the wider medical literature that that Asian patients appear to differ from non-Asian patients with respect to attitudes and perceived need for primary health care services, including general practice services. A number of studies were explored in order to gain further insight and knowledge of the research methodologies used and explore if the outcomes could have any relevance to community pharmacy services. Many of these studies relied on census population and large scale survey data. These studies captured how South Asian patients viewed aspects of health services, communication difficulties, the need for sensitive strategies in health promotion and cultural influences (diet and lifestyle) that affected health and health seeking behaviour. More importantly, the studies reviewed highlighted the relevance of the use of appropriate research methodologies as a research tool to explore specific behaviours and cultural factors. It has generally been accepted that there are problems associated with the way in which health care services are provided for minority ethnic groups. However, very little has been published concerning the interface between pharmaceutical services and these groups, and much of the published work is anecdotal in nature. For pharmacists to have an appreciable role in providing an information service for such groups, it is important to have an understanding of these issues, particularly at local level. Studies have compared the utilisation of services across minority ethnic groups have shown that rates of GP consultations are higher in minority ethnic groups, particularly among South Asian groups. Some of these studies were conducted prior to 1990, and this finding has also been confirmed in a report by Smaje (1996). The relative importance of sex and ethnicity in patients' choice of doctor is not known. In a study by Ahmad et al (1991), a total of 1633 consultations at a health centre in Bradford, with a mixed ethnic list, were examined over a four week period to test the relative importance of these variables. Patients had the choice to consult any one of: a male Asian, a male white or a female white doctor. Asian patients, irrespective of sex, were significantly ( $P$  less than 0.001) more likely to consult the Asian doctor than either of the other two doctors, though a greater proportion of Asian women than men consulted the female white doctor. Although the sex of the doctor was important in patients' choice, for Asian patients the doctor's culture and language were more important.

Ebrahim et al (1991) proposed that Asian elders make relatively heavy use of health services and that this may be due to higher levels of morbidity, but comment that controlled comparisons have not been carried out. A comparison of the prevalence and severity of chronic diseases and use of health services of Asian and indigenous elders were made. A sample of 59 Gujarati Asians of mean age 62.9 years and 59 indigenous subjects of mean age 63.9 years of whom 42% (25 in each group) were female drawn from a general practice was studied. They concluded that Asian subjects had a higher prevalence of diagnosed diseases, with the exception of chronic obstructive airways disease, but lower risk of falls and urinary incontinence. Asian subjects had higher life satisfaction scores and lower prevalence of depressed mood. Asian women were more likely to have had contact with primary care services. Both Asian men and women had more frequent hospital admissions, but similar levels of out-patient attendance. Body mass index, blood pressure and shoulder joint range of movement were similar for both Asians and the indigenous population. Asian subjects had significantly lower peak expiratory flow rates and hand grip strength. Asian elders have a higher risk of chronic diseases, but the impact of disease (indicated by life satisfaction, mood, and common disabilities) is less than among the indigenous population. Lower peak expiratory flow rates and grip strength among Asian elders are of concern since they may lead to premature arrival at age-related thresholds of physical capacity essential for independence in activities of daily living.

Rashid and Jagger (1992) conducted a survey comparing attitudes to and perceived use of health care services in Leicester. A random sample of Asians and non-Asians were interviewed at home in their preferred language using a personally administered questionnaire. The samples were stratified by age group and Asians were chosen on the basis of name, but not further classified into cultural groups. The results suggested the following:

- Language as a barrier appears to be a diminishing problem among Asian patients
- Asian patients reported finding it more difficult to gain access to their GPs than non-Asian patients
- More Asian patients than non-Asian patients would have preferred direct access to consultants
- More Asian patients disliked management of illness by telephone than non-Asian patients
- Asian patients disliked deputising services more than non-Asian patients

- There was some support for 24 hour surgeries, particularly among the Asian population, with doctors working in shifts.

It was concluded that Asian patients appear to differ from non-Asian patients with respect to attitudes and perceived need for health care services. A further retrospective analysis of this study by Rashid et al (1996) compared the views of the Asian and non-Asian patients in the study for their views on 12 different types of medicines (all available on prescription only at the time of survey), with respect to whether the medication should be available as 'over the counter' (OTC) which service users or customers could 'purchase' without the need of a GP prescription. The study, which was conducted through a closed structured questionnaire, also explored whether the patient would like more information about the medication, and who was the preferred source of information on medicines. The findings showed that:

- Asians were generally less favourable towards the medicines being available as OTCs than non-Asians.
- Fewer than 30% of patients wanted more information about medicines, but Asians wanted more information than non-Asians.
- 73-89% of patients surveyed (depending on the type of medication) wanted any drug information to be given by a doctor, with considerably fewer mentioning pharmacists.
- Some effort may need to be taken to persuade Asians to self-medicate and to seek the advice of a pharmacist for minor problems, rather than visiting the GP.
- It was suggested that Asians do seem to desire more information than non-Asians, bearing in mind that their cultural beliefs regarding health in general and perceived need for a better education.
- Pharmacists could seek a higher profile among Asian speaking patients. This could include making information available in minority languages.

This study identified difficulties in identification of patients by ethnicity as this was not recorded in the patients' notes. 'Closed' questioning did not allow further exploration or elaboration of what or how 'cultural sensitivities' were needed by South Asians that required a 'different' approach to healthcare delivery. However, the themes from this study were considered to be relevant to this PhD thesis, and the findings will illustrate further insights as to why Asian patients found GPs difficult to access, why they prefer GPs rather than pharmacists to give them more information about the management of minor ailments. The findings of this PhD study will also illustrate that South Asians were complimentary about the availability of OTC medicines but cost

was the main reason for not purchasing the medicines. The study by Rashid and Jagger did not explore any socio-economic factors that may have contributed to their findings.

Gill et al (1995) carried out a secondary analysis of data from General Household surveys to examine the association between being given a patient prescription and patient ethnicity. (Note: The General Household Survey (GHS) is a multi-purpose continuous survey carried out by the Social Survey Division of the Office for National Statistics (ONS) which collects information on a range of topics from people living in private households in Great Britain.) The authors comment that the issuing of a prescription is central to any doctor-patient interaction. Prescribing variation exists and remains largely unexplained. There is little documented evidence of the effect of patient ethnicity on prescribing patterns. They found that Pakistanis and Indians were significantly more likely to receive a prescription from their general practitioner at a consultation compared to white and West Indian ethnic groups. In addition, consultation rate explained the different prescribing rates among women and men in the white group only. This study raises further questions of the underlying reasons causing these differences which need exploring with GPs and South Asians expectations for this PhD study.

There is little documented evidence of the effect of patient ethnicity on GP prescribing patterns. Gill et al (1997) tested whether Asian general practitioners who qualified in the Indian subcontinent prescribe items more often, more expensive items, and fewer generic drugs than their British trained Asian and non-Asian counterparts. The design of the study involved using data collected by questionnaire and from routine sources in general practices in England. These included 155 single handed general practitioners: 42 Asian doctors qualified in United Kingdom (group 1), 58 white doctors qualified in United Kingdom (group 2), and 55 Asian doctors qualified in Indian subcontinent (group 3). The authors concluded that Asian doctors qualified from the Indian subcontinent did not differ from British trained doctors in their prescribing practice. This study refutes the common belief that Asian doctors are high volume and high cost prescribers. This is important as Johnson et al (1983) also reported that South Asian patients were significantly more likely to register with a South Asian doctor, for various reasons including language concordance.

There is now considerable empirical evidence to show that there are significant differences in the patterns of morbidity and mortality among the UK population, which are correlated with gender, social class, geographical differences and ethnicity. In a study conducted by Cooper et al (1998), the authors assessed whether equity is achieved in use of general practitioner, outpatient, and inpatient services by children and young people according to their ethnic group and socioeconomic background. This was a secondary analysis of the British general household survey, 1991-94. 20,473 children and young people aged between 0 and 19 years were included in this analysis. The authors included consultations with a general practitioner within a two week period, outpatient attendances within a three month period, and inpatient stays during the past year. The study revealed no significant class differences in the use of health services by children and young people, and there was little evidence of variation in use of health services according to housing tenure and parental work status. South Asian children and young people used general practitioner services more than any other ethnic group after controlling for socioeconomic background and perceived health status, but the use of hospital outpatient and inpatient services was significantly lower for children and young people from all minority ethnic groups compared with the white population. These results differed from previous studies, which have reported significant class differences in use of health services for other age groups. These ethnic differences have important implications for the quality of health care received by children and young people.

Since data collection for this study, other surveys of patient experience have revealed wide variation between providers of primary care services in terms of how well they serve the diverse needs of their populations. For example, patients from ethnic minority groups are more likely to report problems with access to care (DH, 2007e). There is increasing recognition that patients' needs and preferences may be complex and strongly dependent on other contextual factors such as consulting GPs of patients' choice, the management of their booking, gender and work patterns of patients (Turner et al (2007) and Gerard et al (2008) , and that changes to organisational policy and practice which aim to drive up quality may not be implemented in ways that are sufficiently flexible to respond to this diversity of needs (Windridge et al 2004).

In 2008, a survey was conducted in Leicester by Ipsos Mori on behalf of Leicester City NHS Trust (Ipsos-Mori , 2008). The survey comprised 2,305 face-to-face interviews across the Leicester City region, with interviews distributed proportionally

across the city's wards to represent the population of each. Interviews were carried out face-to-face, in home, via Computer Aided Personal Interviewing (CAPI). A structured questionnaire was used, with fixed choices. The overall objective of the research was to deliver robust and reliable management intelligence to establish credible baseline measures of public satisfaction and confidence in services and also prevalence of and attitudes towards various lifestyle behaviours across the Leicester City region. Population breakdown by ethnicity was provided. Some findings were broken down by ethnicity, but these were not detailed enough to make comments specifically relating to ethnicity. Overall perceptions of the local NHS services were positive; with most believing local NHS services are providing healthcare users with a good service. These results compare favourably with those of the Department of Health's reports (DH, 2005f, DH 2008e), and suggest that satisfaction with services within the Leicester City region are largely in line with public expectations nationally. However, when respondents were asked how satisfied they were with 12 of their local NHS services, GP and Pharmacist services received the highest levels of satisfaction, but only 39% sought advice from a community pharmacist, compared to 82% visiting a GP. When asked about who they trusted to get information about services, only 5% used the community pharmacist and only 2% trusted the community pharmacist to get information about healthcare. Community pharmacists were less consulted than GPs when patients were asked about six simplified health care scenarios.

In summary, it appears that South Asian patients rely heavily on the GP as their first port of call, and this appears to still be the case. The findings of this PhD study show that these observations are still prevalent, and that the reasons for this are complex, and include more sociological explanations in addition to epidemiological findings. Based on these findings it is argued that whilst epidemiological data can identify trends and differences in practices, it is also important for community pharmacists to understand the health needs of their local population. Other factors such as notion of the 'professional relationship', culturally sensitive provision of information relating to medicines and health and how South Asians themselves feel about their health and health beliefs provide a more holistic understanding of their needs. The next two sections appraise some empirical literature relating to the health of ethnic minorities and evidence of how other professions (including nursing and medicine) have shown how 'culture' has been interpreted to gain a better understanding of how health services are perceived and utilized.

#### **Section 3.2.4. The health of ethnic minorities in UK: a literature appraisal of some key reports**

The results of the first national survey of health behaviour and health status in black and ethnic minority communities added to existing evidence of serious inequalities in the minority ethnic populations (Rudat, 1994). Interviews were held with 723 African-Caribbean, 1017 Indians, 923 Pakistanis and 665 Bangladeshis. Three main conclusions were drawn from this study. There was a need for the provision of interpreting and bilingual advocacy services, Bangladeshi communities showed the worst health profile and traditional health concerns such as diet and lifestyle factors had to be seen in a wider context of social and environmental stress factors. The study utilised in depth interviews as a survey tool and the majority of interviews with the South Asian community were conducted by bi-lingual health workers. The use of community pharmacy services was not explored in this study. The findings and methodology used by Rudat (1994) were important to this PhD study as it was clear that the methodology subsequently adopted needed the inclusion of appropriate research models, and the cost of using these methodologies would have to be based on a smaller scale specifically for this PhD study.

More detailed development work was carried out in February 1996 by the NHS Ethnic Health Unit (EHU). Two projects adopting different perspectives towards the issues surrounding delivery of accessible and effective health care to local black and ethnic minority users were explored by Eccles and Kohli (1996) and Fassil (1996). It was worthy to note that neither study explored the use of community pharmacy services in this population. Both studies utilised a qualitative methodology using trained multi-lingual interpreters and translators where appropriate. Some of the main conclusions and recommendations from these studies highlighted the following key areas which were explored in this PhD study, as these were also considered to be relevant to community pharmacists.

##### *Patient problems and diseases and their management*

The bulk of the consultations by BME/SA patients were for minor illnesses, social problems and psychosomatic illness.

##### *Information systems*

The main problems centred on the lack of recording date of birth, religious language and cultural groups, and the problems of naming systems for producing computerised labels.



### Registration with GPs and dentists

Concerns surrounded the provision of appropriate information to consumers regarding registration and the processes involved with this.

### Inadequate consultation from GPs and referrals

The focus group experience was that GPs did not allow patients adequate time to explain their problems and symptoms. The majority of participants found it difficult to be referred to specialised services by their GPs, despite numerous attempts to explain their continuing symptoms. It was felt by patients that their inability to communicate with the GPs resulted in a non-referral by the GP to specialist services.

### Language and cultural barriers

Concerns were raised about the availability of interpreters to patients at time of consultation and that GPs were unwilling to arrange for them. The use of untrained interpreters was also raised as an issue.

### The provision of interpreter/advocacy services

Two main inter-related problems were language barriers and the need for information about several areas of health care e.g. provision of advocacy/interpreter services

### Inadequate information about services

A common issue raised was the lack of information about service provision in primary health care, GP practices and linked specialist services.

### Health promotion provision

Lack of time and resources (particularly due to the pressures on surgery time from minor illness), negative patient attitudes to chronic illness and health promotion, problems with communication and language and the lack of understanding of cultural issues in giving health promotion advice were cited as the main barriers.

Additional sources considered for this PhD study include the Health Surveys for England, which are designed to provide data at both national and regional level about the population aged two years and over living in private households in England<sup>11</sup>. The Health Survey was first proposed in 1990 to improve information of morbidity by

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<sup>11</sup>(Department of Health website: <http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/HealthSurveyForEngland/Healthsurveybackground/index.htm> (accessed Dec 2007).

the (then) newly created Central Health Monitoring Unit within the Department of Health. This information is used to underpin and improve targeting of nationwide health policies. The survey combines questionnaire answers and physical measurements as well as other objective measures such as analysis of blood samples, ECG readings and lung function tests. It contains a 'core' which is repeated each year and each survey year has one or more modules on subjects of special interest.

The 'core' health areas include:

- questions on general health and psycho-social indicators
- smoking
- alcohol
- demographic and socio-economic indicators
- questions about use of health services and prescribed medicines - the focus for these may vary from year to year to suit the modular content of the survey.
- blood pressure
- measurements of height, weight and blood pressure

The 1999 Health Survey also focused on the health of minority ethnic groups, and included a large-scale 'additional' representative sample of minority ethnic adults and children throughout the country. (DH, 2001; Erens et al, 2001). It was a more extensive survey than the survey carried out in 1994 (Rudat, 1994), and also the first national survey to include minority ethnic children as well as adults. This report highlighted special emphasis on the health of the most populous minority ethnic groups: Black Caribbean, Indian, Pakistani, Bangladeshi, Irish and Chinese. The research methodology included face to face interviews with a researcher and a further visit from a nurse to collect relevant blood and saliva samples. Interviews were obtained with 6,844 adults and 3,415 children from minority ethnic groups. At the second stage of the survey, 4,905 adults and 2,387 children were visited by a nurse. This represents an interview response rate of 88% of adults and 95% of children in co-operating households. The interview response rate among adults for each minority ethnic group was: Black Caribbean 55%, Indian 59%, Pakistani 60%, Bangladeshi 64%, Chinese 62% and Irish 65%. In the general population sample for the main 1999 survey, interviews were carried out with 7,798 adults and 1,842 children. The household response rate was 76%. Data collection for the ethnic minority sample lasted for one year. The survey confirmed again that South Asian population consult the general practitioner more frequently than the indigenous population. From a pharmacy perspective, the survey reports on the use of

medicines, but does not collect data on the use of community pharmacy services. For informants from the target minority ethnic groups, the 1999 survey covered cardiovascular disease (CVD) for adults and asthma for children, as well as the core topics included each year including the use of GP services, dental services and hospital services. This survey provided good background contextual information for this PhD study and the scope for exploring more specific local issues related to this report, particularly in context to the study objectives e.g. local GP utilisation by South Asians and the knowledge of the local health care needs for this population.

There are various well recognised ethnic differences in the incidence of certain diseases commonly encountered in general practice (McAvoy and Donaldson, 1990; Smaje, 1995; Smaje, 1996, Beishon and Nazroo, 1997; Cooper et al, 1998; Gill et al, 2000, Atkinson et al, 2001, Blakemore, 2000; Patel and Bhopal, 2004; Bhatnagar et al, 1995; Bhopal et al, 2004, Aspinall and Jacobson, 2004). Reflecting Government priorities, many of these reports focussed on coronary heart disease, cancers, diabetes, mental health, sexually transmitted infections, communicable diseases, population groups (older people, mothers and babies, children and young people) and lifestyle. They did not, however, consider or refer to, pharmacy services. Table 13 summarises the key factors and demonstrates variation in the evidence available for the South Asian population. National Service Frameworks for some of these areas acknowledge the need for multi-disciplinary team working but do not refer explicitly as to how community pharmacy services could be appropriately utilised.

More importantly the NSF reports concentrate on the 'biomedical' model of understanding of disease and service delivery, and the influence of 'culture' and ethnicity has been acknowledged for targeting South Asians in relation to coronary heart disease (Fox, 2004) and Type 2 diabetes (Christopher et al (2004), Khunti et al, 2009). However, Table 9 illustrates many other health areas which offer opportunities for community pharmacy to be involved pertaining to health promotion and public health. The findings of this PhD study give further insight into how areas such as mental health, cancers (particularly oral cancer), contraception, medicines adherence, diet and exercise are perceived by South Asians, and what community pharmacists should consider providing more 'responsive' services. It is important that communication is important, and the literature has shown that health promotion and education is vital for such initiatives to be delivered, and the evidence for this is appraised in Section 3.2.6 of this chapter.

**Table 9. Key therapeutic risk areas\* in the South Asian population (Bolded\* areas imply that there is an NSF available. \* adapted from Johnson, 2001 (reproduced with permission)**

Therapeutic risk area in South Asians	Availability of Evidence for relevance to South Asians	'Ethnic' Factors that contribute to mortality rates
<b>Coronary Heart Disease*</b>	Good evidence available	Dietary influences Cultural and religious influences (e.g. fasting) Migration Genetic factors
<b>Diabetes*</b>		
Sexually transmitted disease	Limited evidence	Lack of reporting and 'stigmatised' by community influences
<b>Cancer*</b>	Limited evidence but trends show higher rates in the younger Asian population	Less awareness of early signs Chewing of tobacco, betel nut and 'paan' leading to oral cancers Less uptake of cytology and screening services Unawareness of palliative care services Lack of culturally appropriate communication and information strategies
Sickle cell disease (e.g. thalassaemia)	Good evidence	Genetic origins
Asthma <b>COPD*</b>	Limited evidence	Poorer housing Migratory factors
Tuberculosis	Good evidence	Poor understanding of medication use and adherence
<b>End stage renal failure*</b>	Good evidence	Linked to CHD and Diabetes
Visual impairment and cataracts	Limited evidence	Higher incidence in older Asian people; poor uptake of services  Possible relationship to a vegetarian diet and smoking
<b>Mental Health*</b>	Good evidence	Under diagnosis of the condition Lack of culturally appropriate communication and culturally appropriate mental health services Maybe due to cultural and community influences Less adherence to medication
Hepatitis C	Limited evidence	Unsafe medical and dental treatment during travel abroad

For public health, the Wanless Reports '*Securing Our Future Health: Taking a Long-Term View*' (Wanless, 2002) and the update in 2004 (Wanless, 2004) recommended the need for the Government to engage fully with patients and the public in order to deliver better health outcomes. The 2002 report set out an assessment of the resources required to provide high-quality health services in the future. It was based on first catching up, and then keeping up with other developed countries. The report recommended that all NHS organizations form active partnerships with local government and other local agencies to promote population health and reduce inequalities. The report also recommended that particular attention should be given to the needs of minority ethnic groups. (Wanless, 2002 page 128). The report also illustrated the considerable difference in expected cost depending upon how well health services became more productive and how well people became fully engaged with their own health. Resources were needed not only to satisfy short term objectives, particularly access to service, but also to invest in improving supply, by building the capacity of the workforce, improving information technology support and renewing premises, and to invest in reducing demand by enhancing the promotion of good health and disease prevention. The update in 2004 (Wanless, 2004) had focused particularly on prevention and the wider determinants of health in England and on the cost-effectiveness of action that could be taken to improve the health of the whole population and to reduce health inequalities. The updated report concentrates on Public Health and concluded that in order to meet people's expectations and to deliver the highest quality over the next 20 years, the UK would need to devote more resources to health care and that this must be matched by reform to ensure that such resources were used effectively. Wanless et al (2007) published a further report assessing progress over the last 5 years, which showed that more needs to be done to tackle the key determinants of ill health. The report examined whether health care expenditure increased in line with the recommendations from the 2002 review, where the extra money was spent, if the additional resources been used effectively, and if not, why not, and what lessons can be learnt for the future. It was concluded that the raiding of public health projects during the NHS financial difficulties was short sighted, and that the government were a long way short of the fully engaged scenario.

While several PCTs had used Census 2001 data to profile the ethnic mix of their local populations, there appeared to have been relatively little local analytical work on the comparative health status of ethnic groups within local populations. This might have been a reflection of the poor quality of ethnicity data in the relevant databases. While

there appeared to be substantial activity aimed at improving services for minority ethnic groups this was not always based on analysis of need and provision or uptake. Several collaborative projects between East Midlands Public Health Observatory and SHAs and PCTs in the region aimed at providing information to support health equity audit have been produced. (EMPHO, 2004a; EMPHO, 2004b; and APHO, 2005). These reports highlighted the lack of reliable local data and emphasized the importance of developing local data collection systems. The reports were empirical in nature and highlighted many local initiatives to address the needs of the local BME population, but did not mention the use of community pharmacy services in any initiatives. The health areas investigated included mental health initiatives, smoking cessation projects, around such practices as tobacco chewing. There was not much in the way of specific sexual health work with South Asian communities. It was felt that this is because of the sensitivities involved with the South Asian community. Initiatives also utilized community health centres to promote health and interact with the local communities; however, no mention is made in any of these local practice reports of the use of community pharmacies. Communication issues are also key to these initiatives, and this is discussed on Section 3.2.6 (page 114). The findings of this PhD study show that at the time of data collection, GPs and community pharmacists did not routinely capture information of the ethnicity of service users. For community pharmacy this could be more problematic, as the introduction of a 'pharmaceutical needs assessment' advocated as part of the community pharmacy contractual framework (2004) would be utilized to determine what and how services would be better configured to meet the pharmaceutical needs of the local population.

### ***Ethnic minority variations in response to drug action***

Ethnic differences in the way the body responds to drugs have been a relatively neglected area of investigation. In spite of the well recognized inter individual variability in drug responsiveness; most drugs are still prescribed in similar doses to different ethnic groups. There are some studies that have demonstrated an altered pharmacokinetics in different ethnic groups, and this appeared to be mediated by some well recognized physiological differences. A review by Wood and Zhou (1991) examines the evidence for ethnic differences in drug disposition and sensitivity. For polymorphically metabolized drugs, interethnic differences may sometimes be explicable on the basis of an altered frequency of the different phenotypes in different ethnic groups. This area is still poorly understood, and is not included in this research study but may have future implications for further work. Goodyer and Burnham (2009) further highlight that there is still very little research done on how

community pharmacists could potentially benefit from being aware of ethnicity-specific information relating to drug response in order to deliver best advice relating to such issues, as this can have an impact on medicines adherence. The integration of such scientific knowledge could also enhance professional practice, particularly in light of the Medicines Use Review Service.

### **Section 3.2.5. Cultural influences on health seeking behaviour of South Asians**

The inadequacy of health professional education on issues of diversity is well documented in the literature (Gerrish 2000, Culley 1997 & 2000) and the findings of this PhD study will illustrate that this is also the case for community pharmacy. For this PhD study, it was even more pertinent to explore the impact of services and interactions between community pharmacists and South Asians given the constraints of communication and interpretation of 'culture' and 'cultural beliefs' in such encounters. It can be argued that the 'pharmaceutical care' model (Hepler and Strand, 1990) concentrates on aspects of medicines adherence, medicines management and patient safety, and limits the pharmacist's exploration of elements of emotional, physical, spiritual and social health beliefs.

#### ***Cultural competence***

The findings of this PhD study will argue the need for community pharmacists to be 'culturally sensitive' in their approach to services for the South Asian population. In the UK, very little empirical research in the pharmacy domain addresses this issue. However, pharmacy education programmes in the US which incorporate training in 'cultural competence' have been shown to improve patient outcomes including compliance and medicines adherence (Shah et al, 2004; O'Connell et al, 2007). In the UK, there is some literature that emphasises the training of healthcare professionals about 'cultural' issues in managing patients from diverse backgrounds. Much of the evidence comes from models used in nursing care (e.g. Leininger, 1995). Cultural competence is variously defined in terms of the outcomes for individual clients and groups or as the attitudes, and behaviours of practitioners and organisations or a combination of both. While there is never likely to be a single definition which is wholly acceptable to all, the following typifies the definitions found in the literature. It highlights the aims of cultural competence and the attitudes and skills which are essential for its development.

*"... the ability to maximise sensitivity and minimize insensitivity in the service of culturally diverse communities. This requires knowledge, values and skills but most of these are the basic knowledge and skills which underpin any competency training in numerous care professions. Their successful application in work with diverse people and communities will depend a great deal upon cultural awareness, attitudes and approach. The workers need not*



*be as is often assumed highly knowledgeable about the cultures of the people they work with, but must approach culturally different people with openness and respect – a willingness to learn. Self awareness is the most important component in the knowledge base of culturally competent practice.” (O’ Hagan K. (2001). p. 235)*

One of the areas that health care professionals frequently request further training in is ‘cultural awareness’. What is usually meant by this phrase is that the person concerned is looking for a list of ethnic groups and their corresponding cultural rules and rituals about food, religious festivals and observances, washing, dress, and other customs that might ‘get in the way’ of conventional healthcare practices (Culley and Dyson, 2001). However, as shown in some of the empirical literature on the subject in Chapter 2, culture is far more flexible and a person’s health needs are a complex product of gender, age, and status, as well as ethnicity, and individual life history, and cannot easily be ‘read-off’ from their ethnicity. This can also leave the community pharmacist (or other health professionals) with a dilemma. Some pharmacy studies have concentrated on specific ‘cultural’ practices (discussed below). It has been suggested that one could try to learn the principles of a number of cultures and religions and respond to a patient’s presumed needs on this basis (Culley, 2000). Culley proposes that this does not meet the lived and living nature of culture and may indeed lead to harmful stereotyping. Effective cross cultural communication requires an awareness of one’s own values; a respect for difference; knowledge of what aspects of a patient’s culture might be of particular significance in treatment and an awareness of the possibility of operating with stereotyped views of ‘other’ cultures (Gerrish 1996, Culley 2001). It could be argued that such notions are also important for community pharmacy, which is supported from the findings of this PhD study, and further discussed in Chapter 6.

Dogra et al (2004) argue that steps need to be taken to demonstrate the value of ‘cultural competence’ and ‘cultural diversity training’ in undergraduate and postgraduate medical programmes in the UK. Similar arguments have also been suggested for other healthcare professionals (Papadopoulos, 2006). Dogra et al (2004) question the effectiveness of training models on providing desired outcomes. The authors say that different models might meet different learning objectives and it would be helpful for teachers to know this when they are devising educational programmes. Effective instruments for evaluating the outcomes of cultural diversity teaching are urgently needed. It might be possible to derive them from research in other areas, although measuring changes in attitudes and ways of thinking may be fraught with difficulties. In a later study, Dogra et al (2007) also showed that medical

students felt that cultural diversity teaching is more about how to avoid professional, medico-legal pitfalls, rather than improving the patient experience or the patient-physician relationship. However, the researchers surmised that diversity teaching is as much about understanding individuals as it is about understanding groups and cultures. A study by Bentley et al (2008) documented the frequency, regional variation, characteristics and motivations of cultural diversity training through a questionnaire survey of the educational leads of every UK medical school, postgraduate deanery and schools of nursing, physiotherapy, occupational therapy, speech and language therapy, and pharmacy. The results showed a wide variation in teaching practices between healthcare professions and geographical regions. This study provided evidence for the need for national guidelines to incorporate cultural competency training by all UK healthcare professional training bodies (Bentley et al (2008). However, Culley and Dyson (2010) further argue that health professionals should not start to 'learn' cultures in a programmatic way so that these cultural sensitivities can be applied to patients who 'belong' to that culture, neither do they endorse an approach that is only based on individual patients. Instead they propose that, through a combination of formal education, self-directed learning and experience, health professionals widen their *knowledge* about cultural practices.

*'This does not mean primarily 'learning' these practices by rote. Rather it means that the experience of having one's mindset about the world challenged, widened, or reformulated can help develop a more 'open' thinking that is more attuned to possible variations in patient preferences and obligations, variations that may as yet be unknown to the health professional. Once these domains are identified in the health professional's mind, all patients may be asked how the proposed treatment may affect them, and negotiating the course of action with the patient can then begin'. (Culley and Dyson, 2010 page 19.)*

According to the pharmacy code of ethics (RPSGB, 2007b) a pharmacist should also be able to advise the patient on how to continue to take their medication, bearing in mind cultural sensitivities. Although it is more difficult to counsel ethnic groups across a linguistic divide, it is precisely these people for whom the need is greatest. The literature on the health of South Asians has highlighted findings that suggest health care professionals need to be aware of some of the pertinent issues that could affect the health care provision to this population. A brief overview of key issues is

presented in the previous section in Table 9 (page 100) but only a few of these issues have been explored in community pharmacy services or indeed, in connection to medicines use. The findings of this PhD study will illustrate how a wider knowledge of 'cultural' issues could help community pharmacists to have a wider understanding of how such practices and beliefs could be used to explore and provide a more meaningful, culturally sensitive service not just for South Asians, but can in turn, be applicable to all populations.

### ***Dietary factors and the fast of Ramadan***

One of the main issues is the question of diet and fasting: in particular in relation to Islamic principles, which have been frequently referred to in pharmacy 'practice' papers as well as the wider medical literature. Healthy adult Muslims are required to abstain from food and drink from sunrise to sunset daily during the month of Ramadan. This also includes any medication. Compliance and adherence is of great concern in these people who do not take any form of food or drink during daylight hours. (Rashid A, 1992, Aslam and Wilson, 1997; Aadil and Houti, 2004, Benaji et al, 2006). It has been suggested that pharmacists should take a much more active part in patient counselling to ensure that patients are fully aware of the correct dosage regimens and the reasons for compliance (Akhtar, 2001). Participants' views on dietary habits particularly relating to the fast of Ramadan have been further explored in this thesis, as earlier pharmacy studies (Aslam and Wilson, 1992(b), 1997) were not conclusive and used poor methodologies. The findings of this PhD study further illustrate how the knowledge gained about such practices from South Asian participants can be important for having more meaningful interventions such as the intended Medicines Use Review service that was to be introduced during the time of this PhD study. It will be argued that community pharmacists need to have wider knowledge or access to appropriate information about the fast of Ramadan, for example from publications such the Ramadan Health Guide (DH, 2007) as well as from local community leaders and priests.

### ***Use of alternative, complementary and 'traditional' therapies***

In this PhD study, it was pertinent to explore the use of traditional and complementary treatment modalities amongst the South Asian population, including pharmacists' awareness of their use in the South Asian population. There have been numerous articles illustrating the use of 'Asian' medicines by the Asian population in the UK. (D'Arcy, 1991; Aslam and Shaw, 1992a; Bhopal, 1986; Akhtar, 2001; Al Suwaidi et al, 2004, Ali et al, 2005). The authors commented that many of these

treatment modalities were traditional remedies 'prepared in the home through generations' or even obtained through traditional 'practitioners' within the communities such as 'hakims' or 'vahids.' Many of these medicines contained a list of ingredients, which could potentially present a number of possible dangers. Some of these included:

- heavy metal toxicity
- drug interactions (with orthodox medicines) and side effects
- utilisation of unidentified ingredients

A study done by Bhopal (1986) in Scotland also stated that there was little evidence that their use comprised a significant health threat. The study by Jesson et al (1994b) confirmed the views of Bhopal (1986) and negated the picture painted by Aslam and Shaw (1992a). The study by Jesson et al (1994b) also highlighted the use of 'traditional' medicines and 'home remedies'. 30% of the minority ethnic sample in the study indicated that there were times when they preferred such preparations to pharmaceutical products, and 84% of the sample believed they were easy to obtain. The study also reported that (only) 6% of the Asian sample had consulted a Hakim or Vahid ('Vaid' – see glossary). A third of the Asian respondents did not know what the role of the Hakim or Vaid might be and the views volunteered were mixed. Negative perceptions centred around 'illicit' practices and about a perceived 'quackery' preying on the vulnerable. Jesson et al (1994b) concluded that the use of 'traditional' medicines was found to play a modest but not insignificant role within the context of total health care. For pharmacy, Barnes (2003) has published two reviews about complementary medicines. The first reviewed the extent of use of complementary medicines, and issues related to the regulation and pharmaceutical quality of these products; the second considered evidence for the efficacy of several well-known complementary medicines, and discussed complementary medicines pharmacovigilance (safety monitoring). A review by Calapai (2008) enhances the need for further legislation for herbal products. The use of complementary medicines is a popular healthcare approach in the UK, and there are signs that the use of such products is continuing to increase. Patients and the general public use complementary medicines for health maintenance, for the treatment or prevention of minor ailments and also for serious, chronic illnesses, and this is also observed in South Asians (DH, 2001-Health Survey for England, 1999). The use of such medicines is also explored in this thesis, and could this could also be explored in Medicines Use reviews (MURs) advocated in the new community pharmacy contract.

### ***'Cultural' concepts to explain health behaviours***

Research understanding how 'culture' and 'cultural behaviour' can be meaningfully used in pharmacy practice is sparse. An appraisal of some studies in the nursing and medical literature on this subject provided useful basis for the methodology to be pursued for this PhD study, and enlightened the author of this thesis of some of the barriers other health care professionals have researched and encountered. In particular, papers describing the beliefs and management of patients from the key ethnic sub-groups of the local Leicester population were explored.

In a local study by Lindesay, Jagger et al (1997), factors affecting the uptake of health and social services by elderly Asian subjects in Leicester (originating from the state of Gujarat in India -'Gujarati') were investigated. 150 Hindu Gujaratis and 152 whites were interviewed with response rates of 72% for the Asian Gujaratis and 80% for the white groups. The outcome measures were the activities of daily living (ADLs), incontinence, auditory/ visual deficits, cardiovascular disease, cognitive impairment (measured by the Mini-mental State Examination), depression, use of GP and hospital services, knowledge of community health and social services, willingness to use these services, suitability and cultural accessibility. Results showed a poorer uptake of services by elderly Asian Gujaratis and this could not be explained by assuming 'better health'. Significantly more Asian Gujaratis than whites lived with other family member or extended family members (84 versus 52%,  $p < 0.0001$ ) with a greater availability of alternative sources of help and support. Knowledge and understanding of health services were significantly poorer in the Gujarati group; fewer Asian Gujaratis knew how to apply for services and of those applying, fewer had been successful. Where services had been obtained, the levels of dissatisfaction were higher in the Gujarati group. The literacy rates were low in the Gujarati sample with 79% being unable to read or write in English and 27% unable to read or write in their mother tongue. The researchers concluded that the lower uptake of services by elderly Asian Gujaratis is not the result of better health but may be explained by greater family support together with a lack of knowledge of and dissatisfaction with what is available. The researchers surmised that health services would need to be reappraised and revised if they are to cater adequately for this growing population with many needs as yet unmet. It could not be concluded that 'culture' or specific 'cultural influences' contributed to the findings, but nevertheless the importance of the 'family support' or 'community support' needs further exploration. This theme has also been illustrated in the findings of this PhD thesis.

Two further studies in the nursing domain (Webster, 1997, Webster et al, 2002) explored the experiences and needs of Gujarati Hindu patients and partners in the first month after a myocardial infarction and also confirmed the need for exploration of socio-psychological issues underpinning health seeking patterns. These studies used qualitative and quantitative methodologies. The paper by Webster et al (2002) provided further insight into the intricacies of using both types of methodologies with South Asian patients and argued against using quantitative methodology with South Asian patients. Patients and family members found difficulty in completing questionnaires, even though they were in the preferred language of the patient. The qualitative data from the study in 1997 illustrated the lack of availability of information and advice for Gujarati Hindu patients and their families about myocardial infarction and cardiac rehabilitation. There was poor performance of activity, little lifestyle adjustment, poor expectations, lack of future plans, strong family support, dissatisfaction with the family doctor, and a significant belief in 'fatalism'.

A medical study by Greenhalgh et al (1998) explored health beliefs and folk models of diabetes in British Bangladeshis in Tower Hamlets, London. Using qualitative methods, the study findings supported the notion that the similarities in health beliefs and health related behaviours (for example, failed attempts to lose weight or give up smoking) between minority groups and the host culture are often understated and may be of more practical importance than their differences. A recurring theme in the study was that of the role of structural and material barriers to improving health, such as poor housing, unsafe streets, and financial hardship. Hence, the authors argue that there is no value in designing an education programme to be delivered externally to rectify "deficiencies" in knowledge or "incorrect" behaviour. The authors also suggest that health promotion programmes should attempt to build on those beliefs, attitudes, and behaviours already existing in Bangladeshi culture that promote good diabetes control, prevent complications, and improve quality of life, and address practical barriers to positive health behaviours such as non availability of particular foodstuffs and identifying perceptual, structural, and reinforcing factors that influence specific behavioural outcomes in health promotion. The authors re-iterate the broader social and political context within which behaviour change in minority ethnic groups must be placed, and the danger of assuming that "non-compliance" with such advice about lifestyle is always attributable to "cultural factors." Kelleher and Islam (1994) had also contributed to this debate in their qualitative study which examined 'integration' of cultural and religious 'norms' with systems underpinning modern medicine.

*'It is not that the Bangladeshi people have no faith in the professional health-care. They have the problem though of integrating the medical system's global rules with the rules and customs of their culture, the local system. As individuals they have to develop explanatory models which integrate these two systems of knowledge; they manage to do this with varying degrees of success'* (Kelleher and Islam, 1994 p 416).

The authors make a strong argument about the idea of self help groups where people with a particular illness can meet, that can be seen as places where they can share experiences and learn from each other in a non-coercive way, where ideas about treatments and how they work can be offered for others to consider, where the kind of exploratory talk which goes on can be seen as an example of what has been called 'communicative action' (Habermas J. 1981 (cited in Kelleher and Islam (1994))).

An interesting argument about 'concordance' and 'adherence' is illustrated in a study by Lawton et al (2005). The researchers explored the perceptions of diabetic patients of Indian and Pakistani origin of taking oral hypoglycaemic agents (OHAs). Patients' beliefs and use of medicines was influenced by their experience of the health system in their country of origin. They distrusted the system in their country of origin, but admired the NHS. They perceived British healthcare professionals to be competent and trustworthy prescribers. They consequently considered that the medicines available in the UK were likely to be stronger and more efficacious than those available in their country of origin and so they reduced dose and sought to balance effect of medicines by taking in 'traditional' foods, despite advice not to do so. Reasons for this included perceptions that drugs worked by providing relief of symptoms and concerns that OHAs could be detrimental to health if taken for long periods, in conjunction with other drugs, or without traditional foods. In all these respects, the sample reported in this study had more similarities to than differences from the indigenous British population, and most other groups studied in relation to medicine taking (Marinker et al, 1997; Britten et al, 2004). Greenhalgh (2005) argues that the study by Lawton et al (2005) is no less important than it would have been if the authors had detected a set of perceptions and attitudes that were unique to British South Asians. Greenhalgh (2005) also suggests caution about focussing priorities and actions primarily on addressing cultural differences. Instead, it was

suggested that the findings could have been linked more closely with the extensive evidence base on medicine concordance. Grace et al (2008) further explored the 'lay' beliefs and attitudes, religious teachings, and professional perceptions in relation to diabetes prevention in this community. The study used qualitative methodology (focus groups) and explored the views of Bangladeshi people without diabetes ('lay' participants), religious leaders and healthcare professionals. Pharmacists were not interviewed in that study. The findings reveal that 'lay' participants had a fair knowledge about diabetes and its prevention but preferred to take personal responsibility for healthy lifestyle changes, and referred to their religious leaders and teachings for advice on aligning their behaviour patterns to be adapted to cultural and religious norms. The findings also showed that health care professionals admitted to withholding advice because of an incorrect perception of 'fatalism' and the lack of discussing 'cultural' issues. The research methodology for this study was robust, and the authors emphasised that using bi-lingual researchers and investment in time to establish trust in the community and engaging key stakeholders (such as religious leaders) was important to the study.

A Department of Health funded project (Project Dil – see glossary) was set up in Leicester in 1998 to explore and reduce the risk factors for morbidity and mortality from Coronary Heart Disease (CHD) amongst South Asian communities in Leicester (Farooqi et al, 2000, Farooqi and Bhavsar, 2001). The key initiatives include a coronary heart disease training and awareness programme for health care professionals; organisational change to ensure adoption of an effective secondary care prevention programme for general practice and a public awareness campaign involving peer education for the South Asian community in Leicester City. The project, however, did not involve participation with community pharmacists. However, the research methodology involved the use of community health workers to explore barriers, including cultural differences in the understanding of coronary heart disease and the study methodology (which uses community workers to gather ethnographic data) added richness and contextual depth to observed patterns of health behaviour. Much of the debate put forward by the authors of this study emphasises the understanding of 'cultural' issues and, as Kelleher and Islam (above) highlight, to 'integrate' western medical education strategies with 'cultural' norms. The notion of 'fatalism' resonated with the findings by Greenhalgh et al (1998) and Webster et al (1992).

A study by Bissell et al (2004) suggested that qualitative methods of exploration of



concordance factors could also be adopted and that some patients could seek greater understanding and appreciation by health professionals of the subjective psycho-sociological aspects of living with their condition. The study adopted a qualitative inquiry with English speaking patients of Pakistani origin who had diabetes. The authors illustrated through data from their study that if a reasonable level of support for patients is provided through effective interactions with health care professionals, a 'concordant' approach may be more meaningful and achievable. The authors argue that healthcare professionals should foster shared understandings about the material and psychological aspects of living with the condition (in this study it was diabetes) and this could be integrated within the 'medical' model of care. The study findings also illustrated that health care professionals did not understand or appreciate patients' concerns about their day to day life, living with their condition. The authors also suggest that exploring patients' beliefs about their condition and treatment and 'listening' to their interpretations and concerns could be a significant development in achieving better adherence. The study by Barber et al (2004) also illustrates this point and that such interactions are just as relevant for the White population. A meta-analysis conducted by Manias and Williams (2010) showed that relatively little high-quality work has been conducted on adherence-enhancing interventions for people of culturally and linguistically diverse backgrounds. The wider implication of a more pro-active, 'qualitative approach' to re-framing concordant models of care are of significance, particularly with the introduction of advanced pharmacy services like Medicines Use Reviews (MURs). Although the concept of an MUR service has been suggested for community pharmacy (Zermansky et al, 2001), the service processes concentrate more on establishing 'medicines compliance' aspects of patient behaviour without exploring their health beliefs and attitudes.

### **Section 3.2.6. Communication and health promotion for the South Asian population**

There has also been some exploration of how pharmacists communicate with South Asian patients whose first language is not English. The author of this PhD study has attempted to highlight key issues, and reviewed key papers that could be relevant to the role of the pharmacist working in areas of population ethnic diversity. Good communication skills are an integral part of the community pharmacists' role as highlighted in the Pharmacy Code of ethics (RPSGB, 2007b).

The classical definition of communication is "the imparting or interchange of thoughts, opinions, or information by speech, writing, or signs". (from: the Oxford English Dictionary) It includes the process of transferring information from one entity to another. These processes are sign-mediated interactions between at least two agents which share a repertoire of signs and semiotic rules. In other words, communication requires that all parties have an area of communicative commonality and thus requires a process by which we assign and convey meaning in an attempt to create shared understanding. This process requires a vast repertoire of skills in intrapersonal and interpersonal processing, listening, observing, speaking, questioning, analyzing, and evaluating. It is through communication that collaboration and cooperation occur. Hence, the provision of culturally and linguistically appropriate communication in healthcare poses considerable challenges to health policy and frontline service provision.

Poor communication between patients and all healthcare professionals may cause suspicion and mistrust. Many patients feel that they are negatively labelled by the healthcare system and are sceptical of opening themselves to an unsympathetic system. They may therefore appear hostile and aggressive when interacting with healthcare professionals, which in turn lead to distortions and misunderstandings between both groups. The use of good communication skills by healthcare professionals is therefore vital for good healthcare practice (Johnson, 1999; Thomas and Cohn; 2006).

To date, research into communication in health has been targeted at immediate perceived problems. In other words, attention has been focussed on where there are 'evident barriers' to communication, which might be attributable to, for example, language or culture. However, it is important to 'reflect' on such issues, particularly on how well communication is handled both within and outside a team, with particular

attention to models of 'ethnic relations' or 'working with diversity'. Parallels can be drawn between working with people from non-English-speaking backgrounds or different ethno-cultural backgrounds, since it can be recognised that teams, offices, professions, social classes and localities each may have their own cultures and forms of expression (Johnson, 1999).

West (1999) discusses the importance of teamwork, and the role of communication across organisational boundaries in healthcare and that effective communication within multidisciplinary teams leads to favourable outcomes. He also cites research evidence demonstrating that there are better health care outcomes for patients (or service users) if professionals work, learn and communicate together. Interpersonal communication skills are important for pharmacists to master.

Whether it is counselling patients, communicating with physicians, or interfacing with associates, pharmacists use their interpersonal communication skills daily. Effective communication by pharmacists is essential to improve the use of medications by patients and ensure optimal therapeutic outcomes. Health care professionals can improve patient adherence to drug therapy through appropriate strategies, including patient counselling and education (Maguire and Pitceathly, 2002). . In addition to verbal communication, appropriately written recommendations to physicians to resolve drug therapy problems can be an effective strategy for drug therapy changes (Randy, McDonough et al 2006).

There has also been some exploration of how pharmacists communicate with South Asian patients whose first language is not English. The author of this PhD study has attempted to highlight key issues, and reviewed key papers that could be relevant to the role of the pharmacist working in areas of population ethnic diversity. Good communication skills are an integral part of the community pharmacists' role as highlighted in the Pharmacy Code of ethics. Communication skills for pharmacists have been reviewed extensively, (e.g. Hargie et al, 2000; Anderson, 2001). A small study by Abbas et al (1992) looked at drug utilisation among elderly Asian women. The study specifically examined problems in medication taking within a sample of elderly Asian women living at home (n=75). Within this sample patient communication between both doctors and pharmacists was restricted, mainly due to language problems and illiteracy on the patients' side. Most of the patients taking medication had to rely on memory, or other family members to remind them, of the correct directions for their medications. Jessa (1994) reported the results of a small survey of Pakistani patients (n=32) receiving tuberculosis treatment at a hospital in

the UK. It explored the impact of Ramadan on compliance tuberculosis therapy. Assessing patients understanding of an information leaflet translated into Urdu, Punjabi or Gujarati highlighted that 18.7% of patients could read English, although 30% could understand spoken English clearly. Only 37.5% could read their own language. The study concluded that more trained interpreters were needed. The studies by Abbas (1992) and Jessa (1994) had small sample sizes and were not robust enough to make generalisations, but they do illustrate the intricacies of communication about medicines and directions of how medicines should be taken, which are similar to the problems argued by Jesson et al (1994b) for community pharmacists, and also the wider literature.

The wider literature has highlighted that communication is an important access barrier that affects health service utilisation by South Asians. It naturally follows that this could impede effective health education and health promotion in this population. However, the failure of the NHS to adequately address the language needs of South Asian and other minority communities is well documented (Audit Commission 1994, Johnson 1996, Nazroo 1997). Several approaches have been identified within the NHS for overcoming language barriers where verbal communication is required as part of the delivery of services in primary and secondary care. These varied in their effectiveness or 'adequacy', costs, and generalisability to different locations. Until 2005 there were no agreed national standards in language support services other than the criminal justice system and there were discussions underway to establish agreed levels of good practice within the NHS and interpreting profession but these have still not come to any satisfactory conclusion: (Personal communication, Prof M Johnson, Chair, DH Working Group on Language Support in Healthcare (WOLSH)). With language differences within BME groups, it is sometimes necessary to use interpreters, and interpreting guidelines have also been produced in Scotland (NHS Scotland, 2008). However, interpretation and use of interpreters has been debated, and this is also an issue that emerges from the findings of this PhD study. Patient confidentiality may be compromised, and interpretation or translation may not be faithful to the patients account or meaning. Translation takes time and may cause embarrassment, and there is additional cost involved. Three systematic reviews on communication (Johnson, 1999; Szczepura et al, 1999 and Szczepura et al, 2004) highlighted key issues of communication between health-care practitioners and members of the ethnic minorities or ethnic minority groups. Johnson (1999) cited the study by Jesson et al (1994b) and re-iterated the findings around communication with patients in community pharmacy. In particular, valuable insights were gained

when issues around communication were discussed in the study, such as the importance of using verbal instructions, use of pictograms or non-written means of briefing. It should not be assumed that young Asian staff or service users would be fluent in Asian languages. These aspects were also explored in this PhD study. Johnson (1999) also cited the study by Rashid and Jagger (1992) highlighting that Asian service users were not keen on asking for advice on the telephone. Szczepura et al (2004) also suggested that preference would be made for a personal visit because they found body language to be a useful means of overcoming problems of verbal communication. This could also be a source of major concern for the introduction of the telephone help line NHS Direct. Cooper and Chinemana (2004) illustrated that data obtained from NHS Direct needed to be further refined to make an informed judgment of the value of the service. A further study by Knowles et al (2006) showed that those from poorer socioeconomic groups or with communication difficulties were less likely to have used the NHS Direct service than others. The investigators comment that overcoming this apparent bias against those likely to have the greatest need is an unsolved problem not confined to telemedicine. The study by Rashid and Jagger (1992) also demonstrated that South Asians preferred face to face consultations.

Communication techniques for South Asian service users have been explored in other studies apart from pharmacy (Tuffnell et al, 1994; Stone et al, 1998; Jackson and Peters, 2003). A study in Bradford by Tuffnell et al (1994) looked at literacy rates among non-white patients. It was found that the illiteracy rate in the non-white (particularly Punjabi) patients was high. Written information had to be supplemented with audio/video materials to make communication more effective for this particular group of people as well as the availability of interpreters for acute/elective consultations. It was also suggested that these initiatives would have to be adequately resourced. Stone et al (1998) aimed to identify reasons for non-compliance with a screening programme for H Pylori, in a multi-ethnic community setting (in Leicester) and to assess the effectiveness of Asian language materials towards increasing compliance. The study also included a matched group of non-Asian patients. The use of materials in Gujarati did not improve compliance. Stated reasons for non-attendance to the clinics by the Asian group were not generally language related; reasons were similar in the Asian and non-Asian groups and were most frequently related to other commitments. In addition it was concluded that subjects from ethnic minority groups may more generally have insufficient interest in preventative medicine for them to prioritise health screening above other

commitments. Jackson and Peters (2003) looked at improving access to health information for ethnic minority groups by providing this in their own language, in an audio and visual format through a touch-screen computer. The study was led by health promotion and public health workers informed by advisory panels of representatives from local black and ethnic minority groups in the cities of Nottingham, Sheffield and Leicester. A number of problems were addressed in establishing appropriate touch-screen facilities, mainly relating to producing information in an electronic format for multiple languages and populations not necessarily computer-literate. Three touch-screens, containing information on 10 health topics, translated into five languages were installed, one in each city. They were rotated through a series of locations including a library, GP practice, and a temple. Their uses, and satisfaction with use, were being evaluated over a 2-year period, by statistical analysis of computer logs and the collection of quantitative information (via a questionnaire) by bi-lingual interviewers with users, over an 18-month period. Health information can be made available for ethnic minority groups even if they are unable to read their mother tongue, by use of embedded oral presentations. The authors anticipated that the use of touch screens appeared to be a suitable medium for achieving this. The results of this study were published in 2005 (Jackson and Peters, 2005). They showed that touch screens were accessed by 2456 people of all ages, 53% of whom were male. Ease of use was related to home computer use and to being younger in age. Community pharmacies were not used in this study as a site for touch screens but the results from the questionnaire showed that older women from BME needed different ways to access health information.

Further reviews and studies in the medical and nursing literature also highlighted the need for effective communication for 'sensitive' topics such as infertility (Culley et al, 2005), palliative care (e.g. Ackroyd, 2003), mental health problems (e.g. Dein, 1997; Bhugra and Hicks, 2004; Commander et al 2004), thrush (Chapple, 2001), breast screening (Atri et al, 1997), menstrual problems (Chapple, 1998; Chapple and Ling, 1998). Although these do not relate directly to community pharmacy, valuable insights were gained by considering outcomes of these studies. Communication styles and consultation techniques had to be appropriate when discussing these issues which is also true of the white population, but even more so with an Asian population where cultural 'norms' appeared to be very different to the 'white' population, and this aspect will also be illustrated in the findings of this PhD study.

Solutions to overcome such communication barriers have been highlighted in the literature, including technological solutions. These include:

- *Patient selection of health care professionals who could speak their language*
- *The advantages and disadvantages of the use of bilingual health care workers*
- *Feasibility of the use of full-time professional interpreters or experienced sessional interpreters*
- *Use of tele- interpreter services including the use of telephone interpreter services such as the NHS 'Language Line'*
- *Use of patient advocates*
- *Use of volunteer and ad hoc interpreters including the use of GP or pharmacy practice staff*
- *Use of English speaking family members and friends as an interpreter ("Bring Your Own")*

### ***Health promotion and public health in pharmacy***

Effective communication to improving the public's health is a key policy recommendation. It has been acknowledged that community pharmacy could contribute to improving the public's health. The Government's long-term plans to overhaul and modernise the NHS had prompted enormous changes for every health care professional and had highlighted the need for them to develop new and more effective ways of working. Anderson and Greene (1997) and Anderson (1998 and 2000) have highlighted that pro-active health promotion initiatives by community pharmacists have had a variable response from members of the public. Since then, there were two very significant major systematic reviews of health promotion in pharmacy, providing a sound evidence base for the community pharmacists' role in public health initiatives.

Report 1: The contribution of community pharmacy to improving the public's health: Evidence from the peer-reviewed literature 1990-2001 (Anderson et al 2003a).

Report 2: The contribution of community pharmacy to improving the public's health: Evidence from the non peer-reviewed literature 1990-2002 (Anderson et al 2003b).

Both reports looked at existing research data on extending the role of pharmacists in health improvement, examining the opportunities for pharmacists to contribute to health improvement and their current contributions in key areas such as smoking cessation, emergency contraception, lipid management, supply of emergency hormonal contraception, head lice management and drug misuse services. These examples are illustrative only as the thesis is not solely about health promotion, and

a review of this field could exhaust the capacity of the thesis. However, health promotion in South Asian populations was explored in this study, particularly in relation to community pharmacy services. Health promotion has been highlighted as part of the wider Public Health Agenda, the community pharmacy contract and the professional role of the pharmacist. None of the reports commented on the need for appropriately tailored information for South Asian patients, whose information needs may have warranted the need for more culturally acceptable approaches other than translated leaflets, particularly for areas of sexual health and emergency hormonal contraception. While certain services are well-researched and well-received and their widespread implementation was recommended, other services showed promise but required more evaluation to assess their effectiveness and suitability. The reports set out the findings from a detailed review of the UK and international literature. Five further reports have been produced bringing together all the peer reviewed and non-peer reviewed literature pertaining to pharmacy and public health<sup>12</sup>. However, none of these have examined the specific case of minority ethnic / language groups. They do, however, perhaps highlight the importance of future research. These reports placed the findings in the context of overarching national strategies and targets of the main White Paper for Public Health *Choosing Health: Making healthy choices easier* (DH,2004c) and underpinned the recommendations in the related Pharmacy White paper *Choosing Health through Pharmacy* (DH, 2005a). The authors of the reports noted the limited form of evaluations of pharmacy public health initiatives, which made it difficult to assess pharmacists' actual contribution to public health. It was also noted that consideration had to be given to the commercial/ business environment of community pharmacy and the extent of the financial risk to pharmacies in taking part in delivering these strategies. Another consideration was the time and resources required to train and support staff in new roles. In terms of the new Community Pharmacy Contract, this meant that services were more likely to be provided if they are funded at local level as enhanced services.

### ***Use of leaflets***

From personal experience and practice, the author of this study has observed that there appears to be a wealth of written information available to members of the South Asian population, written in different languages covering various disease states. There was also access to linguistic and translation services available at local and national level but none dealing specifically about the use of conventional medicines.

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<sup>12</sup> ([http://www.phlink.org.uk/?q=evidence\\_base\\_reports](http://www.phlink.org.uk/?q=evidence_base_reports) (accessed Dec 2009).



Local “in house” patient information leaflets (PILs) in some South Asian languages had been produced for specific drugs and methods of drug administration by various local hospital pharmacy departments and by the pharmaceutical industry for specific products. Health education and promotion for South Asians has been extensively reviewed in the literature (e.g. Bhatt and Dickinson, 1992; Johnson and Verma, 1998). Bhatt and Dickinson (1992) note that the provision of health education materials in a variety of languages assumes ‘homogeneity’ for different linguistic groups. Reporting a study that identifies epidemiological differences in diabetes prevalence among sub groups of Hindu Indians from the African sub-continent, Bhatt and Dickinson suggest that ‘more finely tuned analysis of such materials is required for particular sub-groups’. This can be problematic, as it cannot be assumed that for example, that people originating from Gujarat would only speak Gujarati and so are assumed to be from the ‘Hindu’ faith. Within a ‘Gujarati’ community, there could be sub-groups which follow different South Asian faiths, cultures and traditions (e.g. Moslems, Jains, Bhatias), the resource implications for producing education materials for separate subgroups and faiths can be enormous. More importantly, community pharmacies are required to display health promotion leaflets as part of their existing contractual obligations, and take part in local and national public health initiatives as part of the new Pharmacy Contract. For pharmacies located in areas where there is a significantly diverse population, having access to such materials could be important to fulfil this contractual obligation. The findings of this PhD study will illustrate if leaflets, translated or otherwise, are in fact used (or not) by healthcare professionals and /or South Asian service users

Szczepura et al (2005) conducted a systematic review to identify and review the available research evidence on 'ethnicity and communication' in areas relevant to ensuring effective provision of mainstream services (e.g. via interpreter, advocacy and translation services); provision of services targeted on communication (e.g. speech and language therapy, counselling, psychotherapy); consensual/participatory activities (e.g. consent to interventions), and; procedures for managing and planning for linguistic diversity. The key messages from this systematic review are highlighted in Box 7 (page 123). There was strong emphasis on the need for research in the evaluation of the recommendations from the review – a theme that emerges throughout the appraisal of the literature in this thesis. NICE guidelines on smoking cessation (NICE, 2008) explicitly mention the utilisation of community pharmacists to reach ethnic minorities and ‘hard to reach’ groups.

Some of the recommendations include:

- Provision of tailored advice, counseling and support, particularly to clients from minority ethnic and disadvantaged groups.
- Provision of services in the language chosen by clients, wherever possible.

The guidance also mentions specifically that community pharmacies serve local communities and have the potential to reach and treat large numbers of people who use tobacco. They are able to meet the needs of minority ethnic and disadvantaged groups and those who may have difficulty accessing other community services. They are contractually obliged to take part each year in up to six public campaigns organized by primary care trusts (PCTs), so they also have an important role to play in local education and communication campaigns.

*'Communication requires attention to context, and the needs of the person seeking to transmit information, as well as the characteristics (language, literacy, culture) of the intended recipient. The messenger may be as important as the message, and some health care workers may not feel comfortable in that role, with particular 'audiences'. Messages must be specifically tailored to their audience, taking religious and other beliefs and practices into account. Information from official sources may be of less impact unless fortified by personal experience and information from intra-community networks which establish a higher level of salience or 'emotional connectedness' with the issues being communicated. UK research and development is so far largely confined to descriptive, clinical, and exploratory work and does not yet include significant evaluation of interventions.'* (Szczepura et al, 2005)

**Box 7. Communication: Some of the recommendations from Szczepura et al (2005) (reproduced with permission).**

There needs to be support for a national telephone interpreter service to match the requirements of 24 hour emergency health care provision.

There is a need to raise the awareness of health professionals on the advantages of having access to trained interpreters and on the limits of using relatives as translators.

Needs assessment is required at national, regional and local levels tied to guaranteed resourcing and evaluation, and adequate time and resource allocated to ensure that initiatives are fully worked through.

Health promotion activity should be alert to the need to move away from printed materials and passive dissemination towards audio-visual presentation and active engagement with minority communities.

More consideration can be given to the use of pictorial representation and pictograms, which are also useful for communication with people who have learning difficulties, as well as use of video materials

NHS Direct Online will require the development of quality assurance procedures for translated patient information materials, and also better dissemination and action to raise awareness of such resources

When considering 'communication', it must be recognised that there is a difference between 'general awareness' and levels of 'detailed knowledge' and that there are different kinds of information field.

Translating material into other languages can send out an important signal to minority communities about intentions to be inclusive.

Interpreters trained 'generically' or for work in legal and commercial settings will require specific training to be effective in working with health specific knowledge

Planners, Commissioners and Providers should work in partnership with black and minority ethnic communities to develop progressive community based health care.

There is scope for the development (and evaluation) of training programmes in:

- use of interpreters (for health care workers)
- managing language support (and language competent) services

There needs to be an active programme of social marketing to overcome possible reluctance of people to request proper language support.

### Section 3.2.7. Professional collaboration

From the government policies highlighted in Table 5 (page 36, Chapter 2) and the literature in previous sections, it is inferred that professional collaboration within the wider aspect of 'professionalism' is an important consideration in achieving the visions of the changes highlighted for community pharmacy. Given the paucity of research on the topic in pharmacy, the following section draws attention to some of the research done on interprofessionalism and interprofessional education by the medical profession in this respect. This is to show how it may help frame understanding of the concept in a pharmacy context and in particular for this PhD study, where the researcher wanted to understand whether new pharmacy initiatives were endorsed by members of the South Asian population as well as general practitioners.

All health care professionals, including pharmacists and GPs receive respect and a level of freedom to practice self-regulation and monopoly. Traditionally 'professionalism' was a characteristic associated with knowledge-based activities requiring long periods of education and training and entailing service for the common good. The model was probably that of medicine, in particular the services of the healer, whose roots can be traced to Hellenic Greece and the Hippocratic Oath. Although the term 'professionalism' had a long history, during which it has had multiple meanings, the term has been discredited and recently re-emerged as an important element in all health professional learning. Its period 'in the wilderness' during the 1970s and 1980s was underpinned by a dual meaning, framed as a conflict between altruism and self-interest. During this period, professions were seen as 'powerful', 'privileged', 'self interested monopolies' which were regarded with scepticism. The role of the 'healer' may have remained fairly constant even if the technology has advanced considerably, but the concept of professionalism has also changed in response to societal and professional needs. In particular, doctor' status and autonomy were challenged and its performance questioned by a succession of challenges.

*There is a social contract between society and medicine that hinges on professionalism. This contract has been and remains largely unwritten, leading physicians to treat it as an implicit rather than an explicit concept. As societal expectations have changed and new demands (are) made upon the medical profession, the social*

*contract has changed and the profession must adapt.* (Cruess et al 2000: pg 157)

One of the important aspects of *Pharmacy in the Future* (DH 2000b) and *A Vision for Pharmacy in the New NHS* (2003b) papers is interprofessional collaboration between community pharmacists and GPs. The inclusion of pharmacies in health centres has created opportunities for general practitioners to become better acquainted with the potential contribution of pharmacists to health care. The literature highlights perceived difficulties by GPs in acknowledging the professional role of the pharmacist. Blenkinsopp and Bradley (1996) illustrated the need for an effective collaboration between pharmacists and GPs as more and more medicines became available through community pharmacies. Hassell et al (1998; 2000b) also noted that whilst community pharmacy was developing strategies to enhance its professional status, it was not so much an attempt at usurping the GPs role as a bid for survival, especially on the part of the 'rank and file'. However, there was also evidence that pharmacists themselves contributed to this situation because many of them also attributed ultimate authority to doctors. Moreover, they were held back by internal occupational divisions particularly between retail pharmacists and employee pharmacists, with the former being the most insecure. This is also evident in later studies (for example, Edmunds and Calnan (2001 discussed below).

A qualitative study by Harding and Taylor (1990) initially explored the extent to which professional collaboration has been realized. Ten health centres with an integral pharmacy were selected, one from each of the regional health authorities in England which had at least one such health centre. Interviews were conducted with 13 general practitioners and 10 pharmacists working in the health centres. Nine general practitioners working in health centres without pharmacies and 10 community pharmacists were also interviewed. General practitioners' attitudes towards health centre pharmacists appeared to differ markedly from the attitudes of colleagues working in relative isolation from pharmacists. It appears that general practitioners working closely with the pharmacist develop a collaborative approach to health care.

A study by Edmunds and Calnan (2001) suggested that while community pharmacy was developing strategies to enhance its professional status, it was not so much an attempt at usurping the GPs role as a bid for survival, especially on the part of the 'rank and file'. However, GPs do not necessarily see the initiatives in this light. The study evaluated some of the key pilot projects that underpinned the

recommendations relating to the reconfiguration of pharmacy services in *Pharmacy in the Future* (DH, 2000b). In addition, the researchers explored the perceptions of people who had a stake in the new services and who would influence their possible implementation in the future, including the service providers (the community pharmacists) and the other health care professionals involved in the pilots (mainly GPs). Both telephone interviews and face to face interviews were used in the study. Areas explored included the use of repeat prescription services and extended roles for the pharmacist in improving medication adherence. The study illustrated that although many GPs are accommodating some changes in community pharmacy, they also perceived some of the initiatives as a threat to their autonomy and control. This was especially evident in representative bodies such as the Local Medical Committee. Doctors' accommodating attitudes were qualified with traditional attitudes of dominance such as 'limitation' and 'exclusion'. The authors argued that such attitudes could prevent community pharmacy from achieving professional status. However, the study also illustrated some evidence that pharmacists themselves contributed to this situation because many of them also attributed ultimate authority to doctors. Moreover, they were held back by internal occupational divisions particularly between retail pharmacists and employee pharmacists, with the former being the most insecure. Edmunds and Calnan (2001) also argued that 'reprofessionalisation' in community pharmacy highlighted divisions between 'retail pharmacists' (owners of independent pharmacies) and employee pharmacists working in large chains as holding back attempts to raise the profession's status. Other studies have shown different aspects of the threats to collaboration.

In a quantitative study by Spencer and Edwards (1992) an attempt was made to ascertain general practitioners' attitudes to an extended role for community pharmacists. Postal questionnaires were sent to a random sample of general practitioners in the Northern, West Midlands, and Oxford regions (n=1087). Questions asked included GPs attitudes towards specific extended roles, pharmacist prescribing of particular drugs (in this case cimetidine, a histamine 2 antagonist drug used for dyspepsia). The role of the pharmacist, and the relationship between the professions were explored. 744 questionnaires were returned (an overall response rate of 68.4%). Attitudes varied, from a majority in favour of pharmacists reporting adverse drug reactions to a majority against their supervising repeat prescriptions (81% and 36% in agreement respectively). A similar range of attitudes was shown to pharmacist prescribing, from 84% in agreement with their prescribing nicotine chewing gum (deregulated since the survey) to 11% agreeing to their prescribing

cimetidine. About half the respondents thought general practitioners should be allowed to dispense and a third that pharmacists "should stick to dispensing." 27% agreed that pharmacists were too influenced by commercial pressures to give unbiased advice. The researchers concluded that most doctors would favour an extension of the activities of community pharmacists but worry about their role in screening and counselling patients and in prescribing. Relationships between GPs and pharmacists were generally felt to be good, although it was inferred that there may be a need for better communication and cooperation locally and for proper evaluation of initiatives to extend the role of the pharmacist.

In a qualitative study done by Hughes and Mcann (2003), the barriers between GPs and pharmacists in relation to closer interprofessional working and the extension of prescribing rights to pharmacists were explored. Three locality areas of a health and social services board in Northern Ireland were chosen for the study. Twenty-two GPs (distributed over five uniprofessional focus groups) and 31 pharmacists (distributed over six uniprofessional focus groups) participated in the study. The 'shopkeeper' image of community pharmacy emerged as the super-ordinate theme, with sub-themes of access, hierarchy and awareness. The shopkeeper image and conflict between business and health care permeated the GPs' discussions and accounted for their concerns regarding the extension of prescribing rights to community pharmacists and involvement in extended services. Community pharmacists felt such views influenced their position in the hierarchy of healthcare professionals. Although GPs had little problem in accessing pharmacists, they considered that patients experienced difficulties owing to the limited opening hours of pharmacies. Conversely, pharmacists reported great difficulty in accessing GPs, largely owing to the gatekeeper role of receptionists. GPs reported being unaware of the training and activities of community pharmacists and participating pharmacists also felt that GPs had no appreciation of their role in health care. The authors concluded that a number of important barriers between GPs and community pharmacists had been identified, which must be overcome if interprofessional liaison between the two professions was to be fully realised. The data in this study were analysed using interpretative phenomenology analysis, and received some criticism (Seamark, 2003) about the validity of the methodology used. The study highlighted another important consideration in choosing an appropriate analytical method for qualitative studies. However, the authors commented that the analysis was appropriate and that the study had been peer reviewed and endorsed the analysis.

Studies by Spencer and Edwards (1992) and Hughes and McCann (2003) illustrate similar findings using different methodologies, despite being conducted almost ten years apart. Particular areas of discussion included the perception of the pharmacy being a 'commercial enterprise' or 'shopkeeper' and although many GPs were accommodating some changes in community pharmacy, they also perceived some of the initiatives as a threat to their autonomy and control. Such areas warranted further exploration in this PhD study, and the findings from this PhD study will still show that such views are still prevalent.

Further editorials by Ford and Jones (1995) and Ambler (2003) endorsed the need for trust and collaboration between the two professional groups if the Government modernisation agenda for primary care was to be successfully delivered. As the literature has shown, there was evidence that South Asians consult general practitioners more than the 'white' population, and the notion of collaborative working and acknowledgment of the professional role of the community pharmacist by GPs could also impact on how the South Asian population viewed the role community pharmacist as this could also impact on the wider services that were envisaged in the White Papers and the potential 'extended' services in the new pharmacy contract. Ambler (2003) commented that perhaps a more straightforward reason why general practitioners and community pharmacists have not developed a trusting and respectful relationship is simply that they don't know one another very well. In the absence of trust and respect born out of shared professional values, experience and even adversity, the professional relationship between general practitioners and community pharmacists may just not be strong enough to sustain joint working in two geographically distant locations. Mutual respect and trust was necessary for the delivery of pharmacist-led services based in pharmacies, as well as surgeries, and may become a universally acceptable development. However, Ambler (2003) also commented that if patients are suspicious of the professional's motives they may feel their needs are not being addressed in the design and implementation of any new services offered. The editorial concluded that health care professionals and policy makers need to be wary of being too introspective and excluding patients from the results of research and policy making decisions and deliberations. Research needed to be inclusive of patients' views without damaging any of the parties' confidence or sense of self worth. In this PhD study further insights are obtained from South Asian participants about how they view the new services which could potentially be delivered.



A comprehensive systematic literature review was undertaken by Bond et al (2003) into the future vision of community pharmacy services and confirms that more evidence will be needed if community pharmacy is to be recognised as a health care provider. The author argued strongly that there had been little research into managerial aspects of pharmacy, and that where this has been addressed it has been interpreted as business orientation. This was perhaps indicative of the inward looking nature of pharmacy practice research reflecting that it often came from pharmacy organisations or departments, and was undertaken by the pharmacists themselves. The author suggested that pharmacy would benefit from a more multidisciplinary approach drawing widely on sociology, psychology, health economics and managerial theory and incorporate research of the reconfiguration of the professional pharmacy role to enhance professional satisfaction. Collectively, these issues and the key themes emerging from the literature present community pharmacy with fundamental challenges in developing the future role of the pharmacy profession in the overall delivery of health care services within the new policies set out by the Government.

Increasing public mistrust particularly of the medical profession has been founded on the belief that professions and professional bodies exist to protect their members (Cruess et al, 2004). The author of this PhD study recognises that the historical definitions of 'professionalism' were not only changing the medical profession but also the pharmacy profession. During the study period, the Governments' policy changed in how NHS services were to be delivered in light of new legislation following major enquiries including the Bristol Inquiry in the UK (Kennedy, 2001) and the Shipman Inquiry (Smith, 2005). All pharmacists registered in Great Britain were guided to abide by their professional code of ethics. More recently, the term 'professionalism' has been 'implied' within the pharmacy code of ethics and this has been described as the "extent to which an occupation or a member of that occupation exhibits the characteristics of that profession". (RPSGB, 2005). In recent years, sociologists and pharmacists have used the term "re-professionalisation" to describe the transition of community pharmacists from pharmaceutical policeman, controlling the supply of medicines, to clinical practitioner (Morgan Traulsen and Bissell, 2004; Bissell and Morgan Traulsen, 2005; Wingfield, 2006). One sign of this process is an emphasis on the need to maintain and refresh clinical knowledge, but it is also essential that pharmacists appreciate other aspects of professionalism coming to the fore, particularly the duty of care to patients (Wingfield, 2006). A vital element of a pharmacist's duty of care is the exercise of professional judgement and discretion.

Occasionally this aspect of a pharmacist's action comes under scrutiny in civil law cases (usually an action for compensation following an allegation of clinical negligence).

The Royal College of Physicians (2005) produced a report which shows the modern interpretation of medical 'professionalism' and the significance of this in modern society. 'Medical' professionalism signifies a set of values, behaviours, and relationships that underpin the trust the public has in doctors. The report, suggested that former notions of professionalism, such as mastery of a discipline, autonomy, privilege and self regulation should be discarded and other notions should be re-interpreted. For example, the inclusion of 'appropriate accountability' rather than an unthinking expectation of blame or not expecting 'altruism' to imply sacrifice oneself entirely for one's profession. The report also suggested that it entailed, among other qualities, the need for judgement in the face of uncertainty and the ability to take responsibility for those judgements and their consequences. The emerging picture suggests that although 'professionalism' was described as being a set of behaviours, values and attitudes that underpin the trust the public has in its health professionals., the definition should now be understood to imply additional qualities, not just expressed in the traditional confines of definitions suggested in the literature. The report suggests that definitions of modern 'professionalism' should include terms such as 'partnership with the patient to secure his or her well being and dignity'; 'partnerships with colleagues based on mutual respect'; and 'partnership with health systems and health organisations'.

More recently, the pharmacy code of ethics has been revised and compliance with its existence has now become a mandatory requirement for practice. (RPSGB, 2007b). The overarching principle defines that the pharmacist must develop and use his or her professional knowledge and skills for the benefit of those seeking their professional services; maintain good professional relationships with others and act in a way that promotes confidence and trust in their services. There are seven core principles underpinning this code and particular attention is drawn to principle 3 of the code of ethics which includes the following statement:

*'In your professional practice you must recognize diversity and respect the cultural differences, values and beliefs of others' (RPSGB, 2007b pg 8).*

During the time the pharmacy code of ethics was being revised, a qualitative study was undertaken by Benson et al (2007). The authors identified two important areas – respect for medicines and respecting the patient's best interests – as key drivers in pharmacy practice. However, the study also identified the tendency of scientific rationality to eclipse or obscure the more personal, ethics-driven values which should inform best practice. Moreover, the study concludes that – again in common with some other healthcare professions – there is a tendency to paternalism, which would need to change to take account of the increased emphasis on patient autonomy and societal change. However, the evidence still indicates that much more work needs to be done to provide the evidence of community pharmacists' contribution as an autonomous healthcare professional. Recent reports illustrate that this radical shift is still not recognised by the medical profession (Bradley, 2009; Richardson and Pollock, 2010). There are still concerns raised about the lack of evidence of the value of new services, and the notion of commercial conflicts of interest. A recent report has been produced to encourage inter-professional collaboration between GPs and community pharmacists, highlighting their roles and responsibilities (BMA and NPA, 2009). It is also perhaps important to note that, despite the significance of 'ethnic mind-sets', none of the above studies have examined the possibility that South Asian GPs may have different views of the role of pharmacy, or that the ethnicity of the professionals might in any way be significant. Additionally, the commercial nature of pharmacy was seen as diminishing professional status. A study by Cooper, Bissell et al (2009) illustrates that pharmacists were very aware of their 'subordinate' status relative to medicine. This argument is also supported in a report by McDonald et al (2010a and 2010b) suggesting that recent reforms to encourage greater use of pharmacists' skills appeared to have done little, if anything, to change that. This is despite the financial incentives to deliver interventions as part of the 'professionalising' strategy advocated by the Government.

## Summary

The literature review in this chapter has shown that there were many variations of the understanding of the role of community pharmacists and the value of services they currently provide. Some of the issues include the use of community pharmacy services by the South Asian minority ethnic population, particularly for the management of minor ailments, health and lifestyle advice. There appears to be a considerable lack of evidence of what works to encourage this population to make better use of pharmacy services. The research methodologies of many studies were variable. It was also frustrating to find the extent to which many of the studies remained 'ethnicity blind', as well as sparse on the exploratory nature of practice research, even when they were seeking to address differences in health seeking behaviour. Similarly, there was not a sufficiently strong evidence base to understand what worked, for whom, in what circumstances and why, which made the spread and adoption of research findings in complex community-based initiatives difficult. Rigorous evaluations of such developments which examined their cross-cultural acceptability, outcomes and costs were lacking. There appears to be a lack of evidence to defend the notion of 'culture' or 'ethnicity' as fixed constraints to explain the variation and complexity of issues surrounding the provision of community pharmacy services. However, there is a wealth of information highlighted in this chapter that illustrated solutions from other healthcare disciplines and programmes that could potentially be adapted for a more pragmatic interpretation for service provision reform that could be inclusive for the needs of South Asian minority patients. It is envisaged that the findings of this thesis will strongly argue the need for more 'culturally competent pharmacy services' to improve the uptake of current and new pharmacy services envisaged in the new government reforms.

At the time of conception and execution phase of this PhD study (2001-2004), the literature illustrated some key questions:

- Are GPs and community pharmacists aware of general beliefs, attitudes and risk factors relating to the health of South Asian ethnic minorities in Leicester?
- Are there any socio-cultural and/or psychological factors which influence the use of community pharmacists by the South Asian community?
- How do GPs and South Asians perceive the new reforms in the provision of community pharmacy services?
- Are there any 'cultural sensitivities' affecting medicines adherence in this population?

- How are communication difficulties overcome?
- Would collaborative working between GPs and pharmacists improve the use of community pharmacy services by the South Asian population?

**The research questions for this PhD study**

What factors affect the use of community pharmacy services by the South Asian population in Leicester City?

Are community pharmacists meeting the needs of service users from the South Asian minority ethnic population for the provision of health advice and pharmaceutical care, particularly for the management of minor ailments?

At this stage, the author wishes to re- emphasise that the (rewritten) reviews in Chapters 2 and 3 include appraisal of policies, reports and studies from a time period mainly from 1980 to 2010. The methodology and methods are described in the next chapter, and these considerations together with data collection were executed between 2001-3, based on the literature that then existed. The discussion of the findings of this PhD study literature review will be used principally to develop the arguments to validate or refute the literature reviewed upto 2004, and will also confirm (or be supported by) or refute some of the later findings in the literature (2005-2010).

# CHAPTER 4

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## **METHODOLOGY, METHODS AND DATA ANALYSIS**

## **CHAPTER 4. METHODOLOGY, METHODS AND ANALYSIS**

This was a qualitative study, shaped by a constructivist enquiry based on pluralistic qualitative methodological approaches. The study was executed over a period of seven years on a part time basis, and was divided into three distinctive phases. The author has split this chapter into five sections, as she describes her journey from the conception of the study through to how the data was analyzed; highlighting her personal reflections of all the processes and in the order they occurred.

In **Section 4. 1**, the author describes and reflects on the theoretical underpinnings of the methodologies used in the study and the justifications for this.

In **Section 4. 2**, the author describes the research strategy, design, reflecting on the main ethical considerations and data collection methods for the study.

In **Section 4.3**, the author describes execution of Phases 1 and 2 and the author's personal reflections of the interviews are highlighted. This section also includes how the author validated the data for the study and describes the execution of the study, including the analytical methods used to examine the data.

In **Section 4.4**, the author describes the processes followed for the analysis of the data, including what steps were included to assure the neutrality and rigour of the analysis.

In **Section 4.5**, the author reflects on all the overall methodological and analytical processes; and describes the strengths and limitations of her experiences. A conclusion and summary of the chapter is included.

## SECTION 4. 1. The research methodology

*'Race and ethnicity in health research have seldom given fundamental new understanding of disease. Most research remains 'black box' epidemiology. Researchers have not overcome the many conceptual and technical problems into ethnicity and health. By emphasizing the negative aspects of the health of minority ethnic groups, research may have damaged their social standing and deflected attention from their health priorities. Unless researchers recognize the difficulties with research into ethnicity and health and correct its weaknesses, 21<sup>st</sup> century research into this subject may suffer the same ignominious fate as that of race science in the 19<sup>th</sup> century' (Bhopal, 1997)*

As illustrated in Chapter 1, the research enquiry arose during the investigator's working experiences as a practicing pharmacist in various settings in Leicester City, including the Trent Medicines Information centre at the Leicester Royal Infirmary, GP practices and in community pharmacies. The investigator is of South Asian origin, and her reflections as an experienced pharmacist who has worked in the hospital, community, primary care and academic setting were important to the conception and design of this study. Two studies (Hassell et al 1998; Platts et al, 1999) had shown that there is a difference in working patterns between 'white' pharmacists and pharmacists from minority ethnic backgrounds, with the latter opting to practice pharmacy as a self employed person or to seek opportunities to develop a business. If this is the case, are community pharmacists in Leicester City, (who are predominantly from a South Asian background<sup>13</sup>) perceived to be 'businessmen? In addition, the author's personal experiences led her to question her own beliefs and ethnocentrism (Chapter 1). As part of this process, choosing an appropriate methodology was a key component and the author needed to explore more appropriate research methods than those traditionally used in scientific research. These questions, along with what had been highlighted from the literature, informed the research aims and outcomes for this PhD study (Box 1 Page 3) and the main research questions as a result of the literature review (page 133).

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<sup>13</sup> the locality has a much larger proportion of pharmacists from an ethnic minority background (32% locally and 20% nationally (Hassell, 2004).



### **Choosing the appropriate methodology for the research question**

Over recent decades, a consistent finding of research into health inequalities among ethnic minority groups has identified inequalities in access to care and in the outcomes of many health care interventions with ethnic minority groups having less good access and poorer health outcomes (Bhopal, 1997; Nazroo, 2003; and Johnson, 2003).

Researching ethnicity and its relevance to pharmacy practice was central to this thesis, the literature highlighted in Chapters 2 and 3 illustrate that ethnicity is also a product of social relationships; relationships that often coincide with social and health inequalities. Understanding how ethnicity impacts on health was (or is) considered to be embedded within the 'social sciences' and is typically concerned with explaining, redressing or justifying inequality. This makes it even more difficult to separate ethnic research from advocacy and taking sides; the concern with pharmacy practice research is that it needs to be perceived as 'equitable'. However, sociology is also a science, a social 'science', and is just as relevant to pharmacy in understanding the 'overall picture' of health behaviours. The research enquiry would allow the researcher to explore the 'hows' and 'whys' at the interface of ethnic relations, health and the pharmacy profession. Recognising differences in ethnicity and ethnic patterns and cultures is an important aspect of how pharmacists can best deliver health services, bearing in mind the common-sense typologies of ethnic groups, understood as bounded social groupings living within specific territories and characterised by an attachment to a core set of cultural characteristics that may not significantly change greatly even by living in a more 'western' environment. Research opportunities would need to be interactive, and can be complex due to the very nature of these social groupings. Bissell et al (2003b) acknowledged a huge potential for further research in exploring the experiences of ethnic minority groups in relation to pharmacy and pharmacy practice, and adding valuable insights on their use of medicines and self care activities.

There is evidence that GPs feel 'threatened' by the new roles suggested for community pharmacists in the NHS White papers (see Chapter 3) and that it was prudent to seek the opinions of GPs about community pharmacists and their professional role and training. This was also apparent from the investigator's practical knowledge of her experiences in working with GPs as a prescribing advisor

and her reflections whilst in practice. The literature highlighted in Chapter 3 indicates that the South Asian population consulted the GPs more frequently than the white population. In addition, due to the lack of plausible data, the views of General Practitioners were an important aspect in gaining an insight of how they perceived pharmacists and community pharmacy services. Their views of the health needs, cultural beliefs and health seeking behaviour in South Asian patients also needed to be further explored in order to confirm the findings in the wider literature on this topic.

Following on from this, it was essential for the investigator to ascertain the views of the South Asian population on how they perceived community pharmacy services and identify what influences their health seeking patterns, including cultural beliefs and explore any barriers to consulting the community pharmacist for health advice. The data could enhance the validity of the findings from the exploratory study with GPs and pharmacists and be used to contextualise the research question and allow for constructive debate by comparing it with findings from the literature and add new dimensions if these emerged from the findings.

In Chapter 3, the investigator acknowledged that published journal articles and research studies discussing ethnicity in relation to pharmacy and pharmacy practice are clearly lacking, both internationally and locally in Great Britain. This thesis concentrates on the 'British' South Asians and the 'British' health services, and it was important to the investigator to consider and appraise the research methodologies used in any relevant studies which were set in Great Britain.

Nationally, other health professionals are involved in looking at ways to improve services to vulnerable groups including ethnic minority patients. The findings Jesson et al, (1994b) used quantitative and qualitative methods to explore the health beliefs of members of the African-Caribbean and South Asian communities, including their use of pharmaceutical services. The study highlighted important methodological issues. The strengths of that study were the findings from the qualitative 'arm' of the study which explored cultural beliefs, health seeking behaviour patterns and barriers to using community pharmacists. Qualitative data was also obtained from interviews with three local community pharmacists about consumer expectations understanding what influences members of the South Asian community. There were clear differences in consultation patterns between the South Asian and the majority white population.

The current PhD enquiry is timely as it was necessary to see if the recommendations made by Jesson et al (1994b) were still valid, and if a more in- depth qualitative enquiry could give a better insight to the findings of that study. The challenge was to also explore research methodologies that could be suitable to further explore issues about the initial beliefs of the investigator, the themes emerging from the literature reviews and utilise other methodologies that could add a further insight to the study by Jesson et al (1994b).

### **Choosing a framework for the research**

As highlighted above, the principal investigator wanted to explore the health seeking behaviours of this population, and the 'hows' and 'whys' behind these patterns. A pragmatic 'common-sense' approach was needed that could be applied to every day pharmacy practice. After considering all the social theories described in the literature (e.g. Nazroo, 2006; pp 39-47; Culley and Dyson, 2001; pp21- 37), this implied a need for far-reaching and critical reflection upon the conceptual underpinnings of the scientific theories informing current policy and practice developments. Being a healthcare professional trained with predominantly positivist principles, the principal investigator leaned toward a more ontological standpoint, in that reality is fixed, and that objective knowledge could only be produced using rigorous methodologies using a more quantitative approach. However, it was also appreciated that knowledge is also influenced by social behaviours and that knowledge is socially constructed. The notion of 'reality' could be ultimately a subjective interpretation. The investigator had to adopt a more constructivist ('interpretivist') approach (Bissell et al, 2002a). As a practising pharmacist, the principal investigator also needed to be pragmatic, and so the study needed to be planned and designed such that the findings could be practically related in the 'real world' setting. So rather than seeking to measure and categorise behaviour and attitudes, and subjecting data to statistical analysis, the investigator wanted to focus on the understanding of health seeking behaviours of South Asian communities. What influences them to use community pharmacists, how they feel about using the community pharmacist and what they think about when they go to the doctors as a first port of call for minor illnesses? By approaching the research question from this position, patterns and irregularities in behaviour could be interpreted to gain further understanding of the situation, and construct a plausible explanation. In addition, the research needed to be credible and acceptable to pharmacy as a profession. The findings need to be credible to practicing pharmacists and allied health care professionals. Thus the principal investigator

considered the notion of 'critical realism'. Critical realism allows the researcher to take a 'middle' ground using a 'soft', constructivist approach (Mcevoy and Richards, 2003). An appropriate research methodology had to be chosen allowing for the gathering of rich, in depth data and then analysing the data using well illustrated and defined techniques and generate plausible explanations using appropriate tools for ensuring rigour validity and authenticity of the findings.

### ***Choosing between quantitative and qualitative enquiry***

Quantitative research is often contrasted with qualitative research. Generally, quantitative research is concerned with numbers and measurement, rather than words, in the collection and analysis of data. Quantitative research usually seeks to establish causal relationships between two or more variables, using statistical methods to test the strength and significance of the relationship. Quantitative social research is rooted in a natural science model of research which sees the social world as amenable to scientific investigation through experimental and statistical processes. The data produced is numerical data which can be analysed in a variety of ways. For this study, choosing the most appropriate methodology was crucial to the investigator. Participants' views needed to be explored in a way which could be appropriately interpreted to throw more light into diverse and open opinions cited in the literature. Initially, using a more familiar quantitative methodology was considered for this study. The principal investigator was more familiar with this approach as this was considered an 'accepted' tool for 'scientific' research. Quantitative research focuses on cause and effect. However the data generated can often lack 'depth' and 'true' meaning (Mays and Pope, 2000; Pope and Mays, 1999 and 2006; Denzin and Lincoln, 2005 Saks and Alsopp, 2007). These assumptions are not made in qualitative research. Every respondent is treated as a single case study that tries to establish meaning to provide in-depth, rich data. However, the lack of external validity and generalisability in the results are some of the major disadvantages using this approach (Murphy et al 1998).

Quantitative research also relies on a 'cause and effect' philosophy. It is about measurement and looks at the behaviour of one item in relationship to another. Variables and interpretations are screened out during the research process. In qualitative research the perspective is very different, it is not concerned with measurements or actual facts, but instead views every individual's representation of the world as mediated and internally constructed and valuable. It is not a fixed truth, it is an attempt to capture what people think and feel and why individuals do things or

act in certain ways. It is about uncovering complexities. The literature emphasises that there is no one prescribed way of doing qualitative research, rather the method used reflects a unique mixture of philosophy, research objectives, participants and audience (Banister et al 1994). Some of the literature appraised in the previous chapters highlighted that there were many 'grey' areas in conducting research with ethnic minorities (Culley and Dyson, 2001, Nazroo, 2006; Johnson, 2006). Choosing qualitative methodology is part of scientific debate. This study did not warrant testing a theory but exploring in depth views and opinions of the service users and providers. Some issues that needed to be explored were complex and sensitive in nature and a quantitative approach would have constrained the principal investigator in the way questions could be formulated.

Additionally, the local knowledge from local field workers highlighted that there was generally a lack of meaningful responses to open ended questions from quantitative surveys and questionnaires, particularly from busy general practitioners, health care professionals and participants from minority ethnic communities. The costs of translated material for questionnaires and surveys were considered, including the consideration of the costs of suitable interpreters to administer them. These limitations were also highlighted in the study by Jesson et al (1994b).

### ***Mixed methods***

'Mixed methods' research means adopting a research strategy employing more than one type of research method. The methods may be a mix of qualitative and quantitative methods, a mix of different quantitative methods or a mix of different qualitative methods. Using mixed methods research also meant working with different types of data. It may also involve using different investigators. For these reasons mixed method research is often referred to as multi-strategy research (Bryman, 2001 and 2004) implying the application of a number of different research strategies related to a complex range of research questions and a complex research design. The advantages of using this research methodology is that it is now being accepted as 'credible' in health services research (Greenhalgh et al, 2005). From the literature review in Chapter 3, 'mixed methods' research tools were adopted in some of the studies. (e.g. Bhopal et al, 1986; Rashid and Jagger, 1992). Data can be 'triangulated' as the method uses multiple sources of data in order to gain greater insight into a particular phenomenon and validate a particular truth, account or finding (Dey, 1993; Miles and Huberman, 1994; Denzin and Lincoln, 2005; Saks and Alsopp, 2007). The data can be gathered from different perspectives and enhances

triangulation, and this the opportunity to understand the phenomenon from a more 'holistic perspective'.

Mixed methodology research techniques were not considered for the initial phases of this PhD study with community pharmacists and GPs. Initial scoping of the study and further appraisal of the research question and findings from the literature warranted the study to begin with qualitative enquiries to 'ground' the findings from the literature and lay the foundation (or groundwork) for a further study which would build on these findings for a more substantive study using both qualitative and quantitative enquiries. The principal investigator concluded that these quantitative methodologies and instruments could be suitable once initial exploratory phases were conducted using an in depth qualitative methodology, after which the findings could inform a more substantive study whereby health survey questionnaires such as the Euroqol (EQ) and Short form 36 (SF-36) could be considered. Both had been widely used and validated (Brazier et al, 1993), and could be adapted for use with ethnic minority populations once a qualitative enquiry methodology highlighted suitable areas of enquiry.

### **The basis for choosing a pluralistic qualitative approach**

This study needed flexibility; although offering a unique chance to collect rich data might have been seen as a threat to the authenticity of the research findings, especially from a "scientific" point of view. The research question was one that was exploratory and a qualitative approach was considered more appropriate. It was crucial for the validity and authenticity of the study findings to have a clear context, where the reader should be able to understand the "where" and "how" of the research method used (Snape and Spencer, 2003). The decision on the exact qualitative research methodology was agreed after much debate as the literature into research question, particularly in relation to pharmacy practice, was sparse. This was challenging. The majority of the published research in Pharmacy Practice leaned towards more 'etic' or deductive quantitative approaches that 'tested' a theory. A methodology taking a realist theoretical approach (Bryman, 2004, Braun and Clarke, 2006) was needed and should involve open questioning, allowing people to represent themselves in their own words so that insight into their social world can be obtained (Ritchie and Lewis, 2003). Ideally, the principal investigator needed to understand the thoughts of people without subjecting them to predetermined or biased conditions. Smith (2002; pp116-117) also highlights that a large body of qualitative work into aspects of medicines use has been conducted outside

pharmacy, and that adapting such methodologies in pharmacy practice research could be useful in influencing future health policies relating to pharmacy and pharmacy practice.

The principal investigator considered a methodology based on 'emic' subjectivist principles (Denzin and Lincoln, 2005). Choosing the most appropriate methodology involved understanding the basic principles underpinning a number of qualitative research approaches. The principal investigator wanted to adopt a more pluralistic and pragmatic approach, and considered further the principles underpinning hermeneutic phenomenology, grounded theory, ethnography and action research. The approaches shared similar values and beliefs and each perspective offered a relevant viewpoint relating to the research question.

### ***Ethnography***

Ethnography means "portrait of a people" and it is a methodology for descriptive studies of cultures and peoples (Brewer, 2000). As a community pharmacist, the principal investigator worked in various health care settings within inner city wards of Leicester which were largely used by members of the South Asian ethnic minority population. She hoped to learn from participants about the prevailing culture that would help her to understand the state of patient care (or its lack of). This included the culture which prevails in a community pharmacy or GP surgery and the way that staff habitually carry out their roles. This would have been an ideal choice for the study. It could have been combined with action research methods and/or case studies as part of a 'mixed method' strategy (described above).

However, ethnography as a sole methodology was not chosen for this study. The methodology would have entailed extensive fieldwork by the principal investigator and time constraints for the study prevented this. Data collection techniques include both formal and informal interviewing, often interviewing individuals on several occasions, and participant or non-participant observation (Brewer, 2000). The project would have been time-consuming because it would have involved the principal investigator spending long periods of time in the field and this would have also impacted on the time constraints for the study. However, the principles of ethnography e.g. observations highlighting 'cultural' experiences were adopted in this study and illustrated as non participant observations as part of field notes and diary entries for important descriptions and behaviours. Examples of such observations have been illustrated in the findings section (Chapters 5 and 6) and reflexive diary

case 'vignettes' in Appendix 5.

The principal investigator did not want to be confined by a methodology that was just restricted to the observation and interpretation of socio-cultural norms of the South Asian population and community pharmacists. Other explanations for the variation in practices were needed, including the views and opinions of general practitioners. However, the core principles of ethnography were favourably considered for adopting a more 'pluralistic' approach. The investigator's own cultural experiences and personal knowledge of the South Asian communities were suggested as key factors. She wanted to be challenged by other researchers and the research team in order to shape the study, interpret the findings and authenticate the results.

### ***Phenomenology***

Phenomenology always asks the question of what is the nature or meaning of something. The focus is on the individual's interpretation of experiences and how they perceive and express what is happening or has happened to them. The role of the researcher is to describe events as perceived and expressed by participants (Ritchie and Spencer, 2002). However, with using this methodology, the researcher's values and beliefs are 'bracketed', preventing them influencing the description of individuals' experiences. Heidegger (translated version of 1996) describes a hermeneutical approach to phenomenology. This situates experiences within a contextual framework and this moves away from the experiences or the phenomenon itself. It allows an individual to describe experiences within a personal historical framework. These behaviours are shared between the researcher and the individual resulting in a negotiated meaning of reality. The confinements of 'bracketing' are removed in hermeneutic phenomenology. As a practicing pharmacist from a South Asian background, it would have been difficult for the investigator to be separated from the experiences of the population and the community pharmacist experiences. This study needed to allow for the fact that different people interpret experiences in different ways. Adopting this method as the sole methodology would not necessarily provide definitive explanations but, the investigator acknowledges that adopting the principles underlying this methodology would raise awareness and increase insight into the research inquiry.

### ***Grounded theory***

Grounded theory was an approach formulated by Glaser and Strauss (Glaser and Strauss, 1967) as an alternative to the deductive 'etic' approach. Theory 'verification'



was at the heart of this approach. In its most pure concept, grounded theory goes beyond phenomenology because the explanations that emerge are genuinely new knowledge and are used to develop new theories about a phenomenon. In health care, such a concept can be used in shaping interventions or approaches to health promotion or the provision of care. It is perceived to be useful where existing research has left major gaps and where a new perspective or insight is needed (Schreiber and Stern, 2001). Using the 'true' principles of grounded theory enquiry requires the researcher to 'enter' the research field with a 'blank sheet' and having no assumptions underpinning the research paradigm. For the investigator of this study to do this was challenging, bearing in mind the time and funding constraints of the study, as well as bringing in prior experience, education and perception of what is happening.

Different data collection methods are used to develop grounded theory, particularly interviews and observation. A key feature of grounded theory is the collection and analysis of data using a procedure known as 'constant comparative analysis'. In this procedure, data are transcribed and examined for content immediately following data collection. Ideas that emerge from the analysis are included in the next session of data collection. For example, a researcher may gradually develop an interview schedule in the latter stages of a research project, which looks very different from the original schedule used in the first interview (Hancock, 2000). At first, this methodology appeared to be very similar to the principles of ethnography and phenomenology. The investigator wanted to compare views of three different participant groups, and allow the emergence of relevant explanations. Comparative analysis was a necessary step in the research process to allow for any developments and explanations for behaviour. The main concepts could be explored with GPs and community pharmacists, and then further compared and explored with different groups of South Asian service users, using the constant comparative technique (Dentin and Lincoln, 2005; Strauss and Corbin, 1990; Strauss and Corbin, 1998; Glaser and Strauss, 1967). The initial results of constant comparison would generate codes, categories and 'themes' that would provide the basis for conducting a 'framework' analysis that would not only clarify an emerging theory but add more meaningful understanding to the concepts identified in the literature on this subject. (Ritchie and Lewis, 2004) This variation in grounded theory methodology allowed the investigator to use a 'holistic' framework based on inductive principles where broad exploratory research questions could be used. Hence, the rigid rules underpinning true grounded theory (Glaser and Strauss, 1967)

which involves simultaneous data collection, coding and analysis, were practically interpreted and adopted to allow for constraints in time and funding.

### ***Action research***

Action research is a methodology that combines 'action' and 'research' together. During a study the researcher is repeating the process of performing an action, reflecting on what has happened and using this information to plan their next action. This process of action research has a refining effect on action and the researcher gains understanding of what is going on (Dick, 1999). Action research as a sole method was not considered for this study due to time constraints. However, the use of field workers and key facilitators is often used in action research, and these principles were incorporated in the final research methodology. This could then inform a more substantive study of practical relevance (encompassing action research principles) that would contribute to the development and implementation of pertinent pharmacy advisory services for ethnic and diverse populations, including a pharmacist led minor ailments scheme. It was the intention that the qualitative exploratory phase of this study would be used to inform a major 'action research' intervention study, which has been described and referenced in the Appendix (Appendix 6).

### **Summary of section 4.1**

The principal investigator concluded that the research question lent itself to the principles or at least the major methods used in grounded theory as well as requiring or suiting aspects of other 'purer' methodologies. The term 'pluralistic approach underpinned by the principles of grounded theory' describes the methodology as this is inter-woven with principles of ethnography, action research and phenomenology. The emphasis upholds the principles of constructivist critical theories that underpin these methodologies, the importance of reflexivity. The relationality to this study is maintained but practical coding processes with the use of a conditional framework matrix can be used. The investigator was able to collect data 'grounded' in the substantive area under research whilst at the same time recognising the relationship between the process of research, the ultimate product and her professional and ethical responsibilities.

The following section describes the final research strategy and design of the study.

## **SECTION 4. 2 . The research strategy and design**

From the previous section, the investigator reflected further on what research techniques and limitations she needed to consider before finalising the execution of this study.

### **Choosing appropriate research techniques for the study**

The literature has highlighted that researching ethnic minority groups can be challenging. It was important for the investigator to appraise how the research was going to be appropriately designed , what data collection tools were going to be used and how the data was going to be analysed, bearing in mind the time and financial limitations for the study. Methodological issues in qualitative research involving ethnic minorities have been highlighted in the literature (e.g. Modood et al (1997); Culley (2000); Johnson (2003); Nazroo, 2006). Box 8 highlights these issues.

#### **Box 8. Important issues addressed in the research design of this study**

Choice of appropriate data collection techniques

Choosing an appropriate sampling process

Ensuring rigour and credibility of the research processes

- The importance of a steering group involving a 'lay' community member
- Minimising inter vs intra group differences
- Avoidance of victim blaming
- Ensure ethnic and language matching
- Minimise the researcher (Hawthorne) effect, including ethnocentricity

### ***Choice of data collection tools***

The final choice of data collection tools for the execution of this study was a particular challenge. This was discussed at the outset as this determined the time and funding required for the study. Constraints on time and funding were important, and the opinions of the steering group and moderators / community workers were carefully considered in order to make the data collection processes pragmatic in order to achieve the aims and objectives of the study. The principal investigator appraised the main issues underlying the data collection processes and has highlighted them below. More specific reflections have been illustrated later in this chapter.

### ***Collection of demographic data***

Having decided to choose qualitative methods for the main part of the study, the investigator also needed to gather quantitative data for the purposes of highlighting demographics and the pertinent characteristics of the research participants and their settings. This would help in 'setting' the scene for the research and allow the reader to understand the context of the research settings and appreciate some of the influences this could have in the research process.

### ***One to one interviews***

Patton (1990) has suggested three approaches to structuring an interview for research purposes. These include open (informal, unstructured) interviews, structured interviews and semi-structured interviews. The 'open' interview was not chosen for this study as these would have involved considerable time as the conversations would be spontaneous and casual. They would have been useful if the investigator had the advantage of doing this in her normal practice setting in a community pharmacy and was observing other pharmacists and South Asian service users in their natural setting. She also wanted to interview GPs and this would not have been possible. The structured interview was also an option to gather large amounts of data in a sequential manner. The study by Jesson et al (1994b) used a 'structured' interview with 'closed' set questions and some open ended questions for studying South Asian participants. The Jesson study highlighted the drawbacks of this technique, including time restraints and costs. The principal investigator wished to explore the use of a different data collection tool to see if she could contribute to the findings of Jesson et al (1994b) as well as get any different perspectives by using different techniques. The use of semi-structured interviews and topic guides were further explored.

Semi-structured interviews are conducted on the basis of a loose structure consisting of open-ended questions that define the area to be explored, at least initially, and from which the interviewer or interviewee may diverge in order to pursue an area in more detail (Britten, 1995). Schedules of 'open' questions could be used to obtain the views of participants and they could also be encouraged to talk freely. It was important that field notes and diaries were used as an additional tool for collecting data (Denzin and Lincoln, 2005) as these could also be used in the analysis. However, one to one interviews with members of the South Asian population were not viable as this would not illustrate the dynamic nature of the data. The study was to seek opinions from a larger number of South Asians who could be allowed to

interact with each other. This needed to be compared to what GPs and community pharmacists were thinking. The principal investigator wanted to explore the findings in order to have a pragmatic understanding about how this population perceives the service and how this understanding could be practically adapted to help community pharmacists respond to the pharmaceutical needs of this population. The use of focus groups for this phase of data collection was considered.

### ***Focus groups***

Focus groups are a group interview or 'meeting' where a group of 6-12 people meet, guided by a facilitator, talk freely and spontaneously about a designated subject, and are particularly helpful in identifying needs, beliefs and opinions. It is a method that capitalises on communication between participants in order to generate data. The discussions may generate more critical comments than one to one interviews. Differences of opinion between people, allow the moderator an opportunity to explore the thought processes of individuals and the rationale for different viewpoints (Kitzinger and Barbour, 1999; Smith, 2002). By involving interaction between participants, focus groups are particularly useful for those who share a common factor. For this study, this factor was the opinions and experiences of South Asian participants. Expression of criticism and the exploration of different types of solutions were invaluable as the aims of this part of the study included exploration of opinions on how to improve community pharmacy services. The information collected arose in the context of natural interactive processes as the principal investigator was mindful to choose participants in their 'natural' community setting.

### ***The use of topic guides (interview schedules)***

The data collection tool used in for qualitative research interviews and discussions is "the topic guide", which consists of a series of questions or topics to cover during the interview. It is generally used to ensure all the basic enquiry lines have been pursued with all the interviewees. The degree of structure in the guide is determined by the format of the interview. The topic guide questions needed to include main questions, probes and follow-up questions needed to avoid double negative, compound and leading questions (Bowling 1997; Smith 2002, Lacey and Luff, 2001). In addition, the basic types of questions include the following: background, descriptive, value, feeling, knowledge/factual and sensory questions (Patton, 2002). Including different types of questions could enhance the richness of the data collected. Prompting is discouraged to avoid leading participants to give certain answers. With all interviews, it is recommended that the interviewer listens well,

does not express personal opinions or appear biased and avoids leading questions. The topic guide questions should be open ended, neutral, sensitive and clear to the interviewee (Britten, 1995; Mays and Pope, 1995).

### ***Sampling***

Qualitative research utilises small samples chosen using non-probability sampling techniques. These usually include purposive, convenience, snowball or theoretical sampling. Convenience samples are usually chosen from an easy to access population to facilitate recruitment. However, these samples may not necessarily represent the range of characteristics in the population studied. This could be avoided by choosing a purposive sample, a technique that is commonly used in qualitative research (Ritchie & Lewis 2003; Smith 2002). The aim is usually to maximise the diversity in the sample. Purposive sampling has been more recently used in pharmacy practice research to explore perceptions of a prescribing role and their training needs (Porteous and Bond, 2003) and is commonly used in ethnic minorities research (Culley and Hudson, 2006; Greenhalgh and Helman, 1998, Johnson 2006). It has been claimed that the purposive sampling method adds power to qualitative research as it selects 'information-rich cases' which can best create the desired data (Borkan et al, 1995). Snowball sampling, where participants are asked to identify others who could participate, is particularly useful in researching difficult-to-reach populations (Atkinson and Flint, 2001). Theoretical sampling is commonly used in grounded theory studies, where participants are chosen to fulfil certain criteria that serve the development of the theory. Hence, the choice of the participants takes place as the research goes on and is informed by the data collected.

The principal investigator and supervisors collectively decided that semi-structured interviews were the most appropriate tool for data collection for this study. Purposive sampling was adopted for the study. In the researcher's experience, time constraints and funding were critical and appropriate sample sizes were carefully considered. The sampling strategy is described for each phase later in this chapter. One to one semi-structured interviews were chosen as the main data collection tool for pharmacists and GP interviews, and semi-structured focus group discussions were used for South Asian participants. Separate topic guides were used for each participant set (see Appendix 4).

## **Ensuring rigour and credibility of the research processes**

### ***Multi-disciplinary steering group***

A multi-disciplinary steering group was appointed to oversee the study, and the details of this group are described in the next section. A community worker was also appointed (see below) as a 'lay member' of the steering group and was involved with the design of 'Phase 2' of this study.

### ***The use of a community worker/lay group member***

The methodology used by Jesson et al (1994b) highlighted the use of field workers and community members to collect appropriate data for the study. Other studies in Chapter 3 have described the benefits of using bilingual community workers to enable better access to research participants and gain a deeper understanding of the research area (e.g. Bhopal 1986; Fassil, 1996; Webster, 1997; Lindsay et al; 1997; Farooqi et al, 2000; Partridge and Hussein, 2002). Working with a community and using community workers can increase a researcher's knowledge and understanding of the significance of what is observed by the researcher in terms of health behaviour and attitudes to health and illness (Johnson, 2006). Whilst exploring how best to utilise the skills of the community worker (DN) a strategy was being used at the Mary Seacole Research Centre, De Montfort University for health research with ethnic minority communities. The 'social action research model' (SARM) is based on the original work by Fleming and Ward (2004). The model is particularly useful in research involving ethnic minority participants in community settings, and where interviews and focus groups feature as the main data collection tools in the research process. The research design for this PhD study incorporates this model. Other researchers doing projects with minority ethnic groups at the Centre were refining and testing this 'model' at the time of this study, and it has been subsequently adopted in several successful projects (e.g. Culley and Hudson 2006, Morjaria-Keval and Johnson, 2005). The model encompasses eight key stages and these are highlighted in Table 10 (pg 153).

For this study, the investigator explored the use of key workers and moderators from the local community for the focus group discussions, interpretations and analysis of the findings. This was necessary to gain access to certain community centres used by the South Asian communities she wanted to interview. Although the investigator is South Asian, her first language is English. She is a Hindu by religion, and reads, writes and speaks fluently in Gujarati. She has limited linguistic skills in Hindi. A trained community worker (DN) was employed to moderate focus groups. DN is a

health worker fluent in Punjabi. Gujarati and Hindi and from a Sikh background. She was chosen as she also has considerable insights and experiences working in many diverse communities. This fits in with the main 'ethos' of the 'social action research model.

### ***Minimising inter vs intra group differences***

Several studies have demonstrated that within some cultural groups in the South Asian community, dynamics of a focus group would be affected by mixed gender sessions (Culley et al, 2006b, UK CRC Screening Pilot Evaluation (Ethnicity) Team, 2003). This could result in biased responses, which may remain unchallenged. Another disadvantage of focus group interviews is that the articulation of group norms (i.e. a majority of participants' comments in 'agreement') may silence individual voices of dissent. Consequently, it is important for the moderator or researcher to create a 'tolerant' and democratic setting in which quiet people were not suppressed by dominant personalities (Kitzinger, 1995; Hibbert et al, 2002). Sensitivity, which includes an awareness of the 'multiple' strands of diversity (e.g. language, religion, history, family allegiances etc) is was also considered important to this research, and the literature in Chapter 3 shows that certain issues such as the fast of Ramadan and certain dietary beliefs would need to be explored in more detail with Moslem participants. If 'South Asian' focus groups had 'mixed' participants of different religious faiths, may lead to competing explanations of findings.

As it was important to the researcher to observe how different members interacted with each other, the investigator needed to be mindful of these issues. She needed to ensure that members of the groups were matched for 'gender' and 'religious' backgrounds as well as 'language' matching in the interviews. The data analysis techniques were chosen so that useful comparisons could be made within the groups and between participant sets. There were limitations to these processes and specific issues that became apparent as the study was executed are acknowledged and discussed later in this section.



**Table 10. The Mary Seacole Research Centre Social Action Model** (adapted from Fleming and Ward, 1999 and 2004; Morjaria-Keval and Johnson, 2005).

<b>Process</b>	<b>Why?</b>
<b>Stage 1: Getting started</b>	Literature review (including grey literature) needs to be reviewed, particularly with local experts and their opinions
<b>Stage 2: Recruit key workers to help with the research</b>	Recruiting and training key workers with an experience of working in communities will help the research process, particularly when principal researchers are from a different background. The inclusion of key workers help the credibility of the research process
<b>Stage 3: Recruit and train community facilitators</b>	Ethnic minority research processes can be hindered by factors such as access, sampling, language barriers, participant recruitment. Community facilitators and advocates can help overcome these barriers. If appropriately trained in the research processes, they can be a useful resource for collecting data, particularly in hard to reach communities
<b>Stage 4: Develop survey questions/topic guides for interviews</b>	Community facilitators should be used for this process particularly as 'ad verbatim' translations can lose meaning or can be difficult to convey to research participants in their preferred language
<b>Stage 5: Conduct interviews</b>	It is preferable for facilitators to use their community's own language, including a 'spoken' language. This can engage participants in a meaningful, pragmatic and non-threatening manner
<b>Stage 6: Review, analysis and feedback</b>	To ensure rigour, authenticity and credibility of the findings, keyworkers are used in the analysis and feedback processes.
<b>Stage 7: Further interventions and action</b>	Using trusted community facilitators encourages assertive outreach and allows information and interventions to be conveyed in a meaningful and pragmatic manner
<b>Stage 8: Evaluation and dissemination</b>	It is necessary for this to be an evolving process and important to be inclusive of the participating communities, practitioners and peers. Findings can then become an integral part of the implementation, and will be acceptable to the final audience and community for which the research was intended.

### ***Minimising the researcher (Hawthorne) effect, including ethnocentricity***

Qualitative research interviewers play an important role as the “primary data collection tool” (Ritchie & Lewis 2003). In the context of interviewing, it is important for the interviewer to be objective and avoid imposing personal ideas and beliefs (Patton, 2002). Instead, the main aim should be to encourage participants to freely express themselves in relation to the topic studied (Bowling, 1997). Although the interaction between the interviewer and the participant is encouraged by some sociologists, however that has the potential of introducing “interviewer bias” and is specially discouraged if the interviewer is novice (Bowling, 1997). It is also essential to try to be as objective and non-judgemental as possible. This could be enhanced through training in interviewing techniques. The ‘Hawthorne effect’ is the name that has been given to the possibility that a participant in a research project may change his or her behaviour in a positive manner simply as a result of being aware of being studied. The converse is also true, in that the researcher may also be influenced by the responses of those being researched.

For this study, the investigator’s role as the main interviewer for interviewing GPs and pharmacists was carefully examined. Being a practicing pharmacist could potentially introduce bias and the possibility of the ‘Hawthorne effect’ could not be discounted. In addition, she is also from a South Asian background and also a ‘service user’ and that this does have a significant effect in her life, both professionally and personally. For this study, the possibility of minimising interviewer bias and the ‘Hawthorne effect’ was enhanced through training of the principal investigator in interviewing techniques. In addition, all the interviews were digitally recorded. Analysis and interpretation would also be conducted by other researchers or key workers to authenticate the findings.

### **The final research design**

The appraisal of data collection tools and techniques and the consideration of the limitations allowed the investigator to design the final strategy and execution of the study.

The research involved 3 phases.

**Phase 1** uses semi-structured interviews to explore the views of local General Practitioners and community pharmacists.

**Phase 2** involves using focus group discussions with members of the South Asian ethnic minority to explore further themes that evolve from Phase 1.

**Phase 3** (time and funding permitting) would reflect and build on the results of

Phase 1 and 2 and takes forward an intervention study examining the impact of a community pharmacist's role in promoting health in members of the South Asian Ethnic minority population, with particular emphasis to the management of minor ailments (see Appendix 6).

### ***Multi-disciplinary strategic input for the research study***

A multi-disciplinary steering group was established to oversee the various phases of the project and provide the investigator appropriate advice and support. This enabled the investigator to embed validity and neutrality at the outset of the research process. The group comprised of:

- **Phase 1** Trent Focus Group and Research Officers from the University of Leicester Hospitals Trust, Leicester (n=2)
- **Phase 1, 2 and 3:** Research Supervisors from the Mary Seacole Centre, Charles Frear School of Nursing and the Leicester School of Pharmacy (n=2).
- **Phase 1 and 2:** A senior local GP actively involved in local projects involving South Asian ethnic minorities (n=1)

**Table 11. Data collection methods for the study**

<b>Phase 1 Interviews with GPs and community pharmacists (data collected by the principal investigator)</b>	<b>Phase 2 Focus group discussions with members of the South Asian community (data collected by the principal investigator and trained moderator/community worker)</b>
Questionnaires for demographic data collection	Questionnaires for demographic data
Semi-structured interviews (one–one in depth interviews)	Semi-structured focus group discussions (using the MSRC research model)
Field note diary records/memos	Field note diary records/memos

### ***Academic requirements for the PhD***

Phases 1 and 2 were registered for academic requirements for this PhD study. The multi-disciplinary team and academic supervisors emphasised that the implementation of Phase 3 of the research was not part of the academic requirement of this PhD. However, the principal investigator was originally required to propose recommendations for a larger intervention study building on the results from Phase 1 and 2, including the preparation for a bid for further funding.

### ***Time and funding for the study***

Preliminary funding for Phases 1 and 2 and the 'work up' for a potential bid for a Phase 3 study were obtained from the NHS Strategic Health authority by the Medicines Information Centre, University Hospitals of Leicester NHS Trust. The time and funding for the execution for an intervention study for Phase 3 was not included. The protocol and funding proposals for the PhD study are available from the principal investigator. The outline for intervention study is also included in Appendix 6.

### ***NHS Ethics approval***

Phase 1: no formal NHS ethical approval was required at the time of this phase for data collection. But as good practice, permission was obtained from the chair of the Local NHS Research Ethics Committee (LREC) to interview GPs and pharmacists in 2001.

Phase 2: Since 2002, full NHS Ethics was required if research included interviews with NHS 'patients' identified from NHS held records e.g. GP databases. (DH 2005g). Some clarity was required as to whether NHS ethical approval was required for phase 2 of the study as it involved interviewing members of the public in a community setting. For confirmation of this, an application was made to the LREC. Letters of confirmation for LREC ethical approval and NHS indemnity cover can be found in Appendix 4.

### ***Considerations for academic institution ethical approval***

Ethical considerations for each Phase of the project have been discussed in the next sections. All necessary paperwork including ethical approval forms, information leaflets, letters of invitation, interview schedules, data collection forms and consent documents can be found in Appendix 4. Full ethical approval for the PhD study was obtained from the De Montfort University Faculty Ethics Committee and can be found in Appendix 4.

### **Section 4.3. PHASE 1: Interviews with GPs and community pharmacists (2002)**

This phase of research explored the views of local General Practitioners (GPs) and community pharmacists on their views regarding South Asian ethnic minority cultural sensitivities and factors affecting service provision to this population.

#### ***Aims***

- to explore the views of local GPs of their perception of the role of a community pharmacist
- to investigate whether GPs and community pharmacists were aware of cultural beliefs of the South Asian ethnic minorities that influence (a) the consultation process and (b) the use of medicines
- to determine if there were any difficulties in communication with this population and methods of how these were overcome
- to determine the personal views of local community pharmacists of their professional role in meeting the needs of the local population
- to explore any incentives and barriers community pharmacists perceive in providing effective services to the local population

The findings identified initial areas of the knowledge about the cultural beliefs that influence a GP consultation process. The findings also allowed the investigator to understand how GPs perceive the role of the pharmacist in addressing patient education and patient information needs of members of the South Asian ethnic minorities. These issues could then be further explored with community pharmacists to see if there were any similarities or differences in the views.

#### ***Information, confidentiality and informed consent***

A letter of invitation was sent to each respondent prior to the interview in which the research and the methodology were explained. Verbal consent was obtained from the interviewees and an appropriate time set to conduct the interview at their place of work. Prior to each interview the researcher's intentions, the research aims and objectives were fully explained. This was done ten minutes prior to the interview face to face or by telephone one day prior to the interview. It was also explained that the interview would be fully confidential and that when the data had been fully analysed the final draft would be anonymised. The confidentiality and anonymity of the data

was given high priority and emphasised as such. The respondents were also told that they could stop the interview proceedings at any time they deemed it necessary. Their wishes would be fully respected by the researcher. None of the respondents refused to take part in the study. The researcher recognises that privileged access is an issue within the research process, as most of the participants did previously know the researcher. Hence this might have been an advantage. In this way, the participant and the investigator were assured of the importance of informed consent. Ethical considerations are crucial to this particular aspect of research because of the sensitivity surrounding race and ethnicity.

### ***Researcher safety***

Data was collected by the investigator in the participant's work setting or a University based setting where there was a 'third party' on the premises and this posed no risk to the investigator.

### ***Choosing the sample***

Members of the steering group identified the sample for this research project. The GPs to be interviewed were identified as being responsible for overall patient care in the Primary Care setting and could therefore provide valuable initial background data around their perceptions of the health of and provision of pharmacy services to members of their South Asian minority patient population group. GPs from both single- handed and multi-partner settings were chosen. Community pharmacists from independent, multiple and locum pharmacy backgrounds were chosen to ensure a fair spread of occupational settings. Purposive sampling techniques were adopted for this phase.

The sample was chosen by identifying similar demographic and epidemiological population characteristics of the Belgrave (mainly Hindu), Highfields (Mainly Moslem and Sikh) and Loughborough (mainly Moslem Bengali) areas of Leicester. GPs and community pharmacists were chosen by mapping postal codes of GP practices and community pharmacies to the demographic areas. Ten GPs (5 from South Asian background) and ten community pharmacists (5 from South Asian background) were originally invited to participate in the research. However, after letters of invitations were sent and several telephone calls consent to participate was received from the following participants:

- Six GPs (2 'white' (or European) and 4 South Asian)
- Five community pharmacists (2 'white' (European) and 3 South Asian)

During the time of the study (2001) there were 64 community pharmacies and 52 GP practices in Leicester City. The author of this study acknowledges that the sample size was small and this was a major limitation of the study. The time frame and funding limitations of the study were reconsidered, and the principal investigator would have reconsidered the sample size. The findings from the interviews were considered by the investigator and the research team as 'saturation' of the data was not reached. However, the data collected still provided exploratory data that could be used to understand some of the findings obtained from the focus group data with South Asians (Phase 2) which is illustrated in the next chapter.

### ***Quantitative Data collection***

Prior to the principal investigator contacting the respondents, it became apparent during the initial process that some demographic details were needed to help 'set the scene' at the interview and to provide background data for the study. A quantitative approach using a questionnaire was used for this purpose (Appendix 4). This allowed the researcher to determine the background of the participant and pertinent demographic details of their practice and patient population. It was anticipated that this information would enable the researcher to 'open up' the interview process and where necessary and to probe into more specific areas during the interview. The questionnaire was sent to the interviewees prior to the interview.

### ***Interviews***

'Unstructured' interviews could have been used, but with GPs and community pharmacists, time constraints were paramount. Interviewing GPs meant that the discussion would need to remain focussed. With community pharmacists who may keep getting interrupted, the interview schedule needed to be timed carefully, and the interviewer alert to refocus the participants. It was concluded that a 'semi-structured' interview design was more suitable as this could help with dialogue and provide a 'focus' to the discussion.

Two separate interview schedules or topic guides were produced (see Appendix 4). The questions were used in a flexible, purposeful order that would allow the participant to build upon the understanding of topic asked and any previous points raised during the interview process. Open-ended questions were included as this invited the participant to discuss their views and opinions in a 'free' manner. It also ensured that their thoughts and feelings were expressed using their own words. Care was taken when clarifying any questions raised by the participant, as the

principal investigator was aware that it was important not to lead the conversation or influence its outcome. Probes and prompts were also included in the guide, and used only if there was a need for a more focused approach or if the respondent was unsure of the question asked. When the interviewees began to discuss material that related to another question or area then the sequence order of the questions was changed. Other issues that were relevant to the research agenda but not included in the topic guide were also allowed to be discussed, time permitting.

The topic guide posed eight open-ended questions for the GP interviews and nine questions on the pharmacists' interviews. The areas covered in the interviews are shown in Box 9.

**Box 9. Broad ideas explored in Phase 1 interviews**

Knowledge of (South Asian) patient demographics
Communication
Consultations and health seeking behaviour (including minor ailments)
Knowledge / training of cultural beliefs and ethnicity
Role of the pharmacist
Government initiatives to 'modernise' pharmacy services
Health promotion

These themes arose in the literature (see Chapters 2 and 3)

***Pilot interviews***

Three pilot interviews were conducted with two research colleagues and one community pharmacist, one of whom was of South Asian origin. The interview could not be piloted with a general practitioner due to time constraints on the part of the GPs. This was a limitation of the interview methodology. Pilots were conducted to ensure the sensitivity and cultural acceptability of the questions as well as the professional clarity of what was being asked. Some minor changes were made to the interview schedule as a result of suggestions made by the participants of the pilot study.

***The interview process***

Five interviews were conducted with GPs (one interview was with 2 GPs) and five with community pharmacists. The interviews were carried out in the interviewees



working environment and at a suitable time for the interviewee. Each interview lasted one hour (on average) for the GPs and one and a half hours (for community pharmacists). The interviews for phase 1 were conducted by the principal investigator. At the beginning of the interview she started by thanking the GP for taking part in the study and filling in the appropriate questionnaire for the collection of demographic data. The introduction letter was discussed with the participants and the investigator answered any questions and assured them that their comments would be anonymous.

Informed consent (see above) from each participant was obtained using the consent form. A detailed information leaflet was available for all participants, and they were informed that they did not have to participate and could withdraw at any time. All Phase 1 interviews took place at the participant's workplace at a time convenient to them during office hours (with a third party close by). This ensured that the participant knew the environment and also that the time they were offering was limited to the interview process and not in travelling as well as ensuring personal safety of both the participant and the investigator. All the participants felt comfortable during the interview process. Time was set aside before and after the interviews to talk informally. Care was taken to adopt a friendly, enthusiastic, interested and non-authoritarian approach, conducive with building rapport. A request to record the interview was also made at the start of the interview. Participants were reassured that all data would be stored and treated according to established procedures governing research ethics. They were informed that information provided would remain confidential, however suitably anonymised quotes may appear in the final report. Field note diary records/memos were also kept throughout the interviews and these entries were used as part of data collection.

### ***Recording interviews***

All interviews were audio-recorded using a Sony Digital Voice recorder. The investigator wanted to be attentive to what was being said and did not wish to be distracted by having to take notes or having to ask participants to repeat answers. The tapes were stored in a locked cupboard until all the recordings had been transcribed and the data analysed, and were destroyed after this process.

### ***Confirming the interview findings of Phase 1***

At the end of each interview, the researcher summarised the main findings of the interview for the participants. If there were any additions or clarifications, they were

noted as separate diary entries and included in the data. She contacted each GP and community pharmacist four weeks after the interviews were conducted and transcribed. A verbal summary of the main interview findings was discussed with each participant on the telephone. They were all offered a full transcript of the interview and all declined to receive this. All participants agreed to receive an interim report of the research six months after the interviews had been conducted and the main analysis had taken place. This report illustrated the main themes and interpretations from the findings. They were invited to contact the principal investigator if they disagreed with the interpretation or any of the findings. To date, none of the participants has contacted the investigator. This report is included in Appendix 7.

The findings and discussion of the results of Phase 1 are described in Chapter 5 of this thesis.

## **The principal investigator's reflections of the interview processes for Phase 1 interviews**

### ***GP Interviews***

An interview with the GPs had to be carried out after surgery hours and this led to some cancellations due to GPs on-call commitments. Ten GPs were invited to participate in the interviews but only six could be interviewed due to cancellations and time constraints. There was varying enthusiasm for the study. However, the contacts developed with me whilst the researcher was practicing as a primary care pharmacist and the relationships established with the steering group did help in gaining access to GPs. All the GPs participants were very open and wanted to talk about the research topic. They were all aware that the researchers were speaking about South Asian communities from India, Sri Lanka, Pakistan and Bangladesh. The principal investigator asked all of the GPs when they were last interviewed about the community pharmacist and pharmacy services and most of them indicated that they had never been asked for their opinions on the subject. Five GPs knew the researcher professionally, and as such, this could have been very influential in their receptiveness to questions. However, some GPs had to be probed quite assertively when they were asked to comment on the role of the community pharmacist, particularly around their ideas on extended roles. The investigator thought it particularly important to keep a reflexive log and diary of all the interactions that were not captured on the tape recording. These entries to be just as important to the interview findings and were used in the analysis to further illustrate and enhance the

findings.

The practice settings were quite diverse, even within the same area within Leicester City. In Appendix 5, the researcher has illustrated two 'vignettes' of GPs and their practice settings to give the reader a perspective of her observations.

The findings of the GP interviews for Phase 1 of this study have been published (Lakhani et al, 2002)

### ***The community pharmacist interviews***

Interviewing community pharmacists at their workplace was particularly difficult when they were the sole pharmacist on duty. Interruptions in the interview process hindered a train of thought and clarity and the respondent had to be reminded on several occasions about the topic discussed. This could have contributed to the disparity in the responses obtained during the interviews.

Ten minutes into one of the interviews, one South Asian participant (participant 5) was under the impression that the researcher was talking just about the 'Sri Lankan' community. The researcher explained the term 'South Asian' to him again. She went over the topic guide questions again and the interview proceeded with this clarification. It was important that the definition of 'South Asian' was clarified with other participants, who acknowledged and that they had understood 'South Asian' to include people from Pakistan, India and Bangladesh and Sri Lanka.

For the reader to have a better understanding of the different types of community pharmacy settings used in the study, the principal investigator has illustrated two pharmacy case study 'vignettes', highlighting the complexity and disparity between the settings of an independent pharmacy and a large multiple. These are illustrated in Appendix 5.

All the pharmacists interviewed knew the principal investigator in her role as a professional colleague. The advantage was that they opened up as the interviews progressed as they felt 'comfortable' talking to a fellow professional and some of the participants were quite candid with their comments. The discussion had to be brought back to focus on the research topic at several points during the interview.

There were disruptions despite choosing a quiet time to conduct the interviews. They were all conducted in the practice setting, and there was no best time to do these except for a lunch time period or after close of business. One pharmacist (participant

5) agreed to do the interview after close of business, but even then there were interruptions as he insisted on doing 'late' prescriptions for patients who knocked on the door after closing time.

Participants had to be probed to give more objective responses about the new Government initiatives and how they felt about their future roles. The researcher thought it particularly important to keep a reflexive log and diary of all the non verbal clues and interactions she had with the pharmacists as she considered these entries to be just as important to be used in the analysis to further illustrate and enhance the findings (as with GPs).

## **PHASE 2: Focus groups with South Asian participants**

Using the findings of the literature review (Chapter 2 and 3) and Phase 1 of the study, the principal investigator wanted to explore the views of a selection of members from South Asian community about their experiences of community pharmacy services, and whether there were any cultural issues that influenced their health and health seeking behaviour. The processes used in Phase 1 of the research were also followed for Phase 2. In addition, the social action research model described on page 155 was adopted.

### ***Aims***

- To investigate the views of members of the public from South Asian ethnic minority background on current pharmaceutical services, including
  - a) the role of a community pharmacist
  - b) the use of community pharmacies for health advice
- To explore current methods used for the provision of information /advice relating to the use of medicines, particularly for minor ailments.
- To explore influences (including cultural) relating to general health of this population and the use of medicines (particularly for minor ailments)
- To explore views on future initiatives around reconfiguration of community pharmacy services

(Please note that examples of consent forms, patient information leaflets, data collection forms and topic guides are included in Appendix 4).

### ***Stage 1: The literature review***

This was used in both Phases and has been described in detail in Chapter 2.

### ***Stage 2 and 3: Recruiting and training a key facilitator***

Advice was sought from a health worker (Davinder Nagra, (DN)) with experience of community working (link worker and patient advocate). She consented to be a moderator for all the focus group discussions, and was fluent in Gujarati, Hindi and Punjabi. She is an active link worker and assisted in various local research projects with ethnic minorities within the Primary Care Trust. She was briefed on the pertinent aspects of the study prior to the interviews and trained on the key aspects of areas for exploration in the interviews. A detailed topic guide was produced to help with the

training (see Appendix 4).

#### ***Stage 4: Ethical considerations***

It would have been ideal to identify patients who had multiple GP consultations or Pharmacy consultations for minor ailments. However, NHS and Department of Health regulations for data protection and research governance require explicit ethical approval and consent in order to access patient records which would be required to identify such cases. In addition, given that neither GPs nor pharmacists medical records captured the ethnic background of the patients; it would be time consuming to identify suitable patients from the medical records. Problems with name recognition has also been highlighted in the literature (Jesson, 1994b, McFarlane et al, 2007; Smith, 2002). The research team considered it important to get a true perspective of community members, and it was decided to contact members of the community through opportunistic methods with the help of community centre managers.

#### ***Information, confidentiality and informed consent with South Asian participants in the study***

The investigator considered the possibility of having the leaflet translated into Gujarati, Hindi, Punjabi and Urdu languages. From the initial findings of Phase 1 of the study and the literature review, it was considered that translated patient information leaflets and consent forms may not be read. The principal investigator and steering group members considered that informed consent would be needed, and that this would need to be verbally communicated to all participants. Such methods have been considered in studies by Barnett (2008) and Lloyd et al (2008). After consulting with the 'expert' community members the steering group concluded that they would use DN and approach the community centre managers to verbally communicate the information about the project and help to recruit appropriate participants for the research. Participants also signed the declaration of consent.

#### ***Researcher safety***

The use of community based groups was deemed to present no risk to the researcher. However, the moderator (DN) advised the steering group that the interviews should be done in the presence of two people, particularly with male groups. This was deemed not only as good practice, but ensured researcher safety as both the key worker and the investigator were female. This is also approved by various community centre managers and the community elders within most chosen

community centres in Leicester. This would encourage recruitment and participation.

#### ***Stage 4: Choosing the sample and location***

There was general consensus with the steering group and it was concluded that focus groups with South Asian communities are most successful when organised around social groupings including identifying participants from community settings. In addition, single sex settings were considered appropriate as the keyworker and researcher would find it more comfortable and appropriate to probe sensitive and cultural issues. Punjabi, Moslem and Hindu group participants were chosen as these were the main descriptors and religions highlighted in the 2001 census data sets for Leicester City. The steering group decided to exclude Bangladeshis because of the logistical problems of including a third language group and the small numbers resident in Leicester City (2001 census). Five community centres in Leicester City were initially chosen and contacted by letter inviting them to express an interest. There were no replies when this form of communication was used. The researchers concluded that the best way of recruiting suitable participants was to personally contact the community centre managers both via the telephone and personal visits. Three community centres were identified for recruiting the participants. All three community centres were used by people from a wide age range, and frequently held PCT led events related to health and health promotion.

The key worker and researcher made appointments to speak to the centre managers and give them as much background to this project. Advertisements and posters could have been used, but the researcher was informed by DN that in her experience, such information was not read and needed to be explained by the centre managers by way of announcements at the community centre events. The centre managers suggested that information leaflets could be left with them and they would give these out to people who showed an interest and had family members that would encourage them to participate. The invitation to participate was left 'open' and that the investigator would contact the community centre managers three days before the event to check the level of interest. The notion of 'snowball sampling' after the initial 'purposive sample' identification was an effective method for recruiting participants for this phase of the study.

This method of recruitment was successful and the investigator was informed that at least 6-8 participants from each community centre would be interested to participate in the study. All participants were informed that they would be paid a maximum of £5

for their travel expenses and that light refreshments would be available. Potential participants were given a brief outline of the topic by the centre managers and informed that there would be two people conducting the focus group in their chosen language.

As a result, a total of 55 participants from six focus groups (from the Moslem, Hindu and Sikh communities) were convened and interviews conducted in these settings (see table12). Appendix 4 illustrates the full profile of focus group participants for this study.

**Table 12. Community centres identified for Phase 2**

	Description	Focus group
Belgrave Neighbourhood Centre (Ward: Belgrave)	A neighbourhood Centre used by a predominantly Hindu community.	Hindu (male and female)
Sri Guru Teg Bahadur Gurdwara (Ward: Spinney Hill)	A centre and Sikh temple used by a predominantly Punjabi community.	Punjabi (male and female)
Moslem Khatri Association (Ward: Spinney Hill)	A community centre used by a predominantly Moslem community	Moslem (male and female)

### ***Stage 5. Developing the data collection tools and techniques***

A questionnaire was designed for gathering demographic data (see Appendix 4). This was for participants to complete themselves or could be administered by the interviewers. For all participants, this included the post code of residence, gender and age, length of residence in the UK, country of origin, preferred spoken language, number of family members residing with them and if they had returned to their country of origin in the last 10 years. Exploring these areas would help the DN and the investigator to probe for clarity and depth of answers, particularly around the influence of different family generations on health seeking patterns and if this behaviour was influenced by external influences abroad. Full details of the demographic data of all focus groups can be found in Appendix 4.

A topic guide was produced to explore areas identified in the literature as well as emergent themes from Phase 1. The topic guide remained flexible enough to allow the emergence of new data. Interview transcripts from Phase 1 were analysed first.



The themes that emerged from the data subsets in Phase 1 interviews were used to develop the topic guides for Phase 2 of the study. In this way, one of the principles of grounded theory analysis was adapted in the methodology.

### ***Pilot discussions***

DN and the principal investigator piloted the interview with four friends and colleagues who spoke key languages including Punjabi, Gujarati and Hindi. The pilot highlighted that certain words needed to be clarified using various examples in the 'spoken' language and that both the principal investigator and key worker needed to remind each other of these phrases during the interview.

Additional clarifications, suggestions and examples that were needed were for the following words:

*Minor ailments:* need to cite examples such as a simple cold, temperature, dry skin, sore throat in an appropriate, non alarmist way.

*Pharmacists:* may use 'chemist' as this is more 'understood'.

*Complementary and alternative therapies:* advised to give examples of herbal medicines, 'home made remedies' that South Asians use such as the use of turmeric, honey and ginger.

*'Hot' and 'cold' beliefs:* literal translations for the terms hot and cold could be used and then clarified as needed. This would be a difficult term for the investigator to understand in 'natural' conversation with participants and may need to be explored using examples. The topic guides were adjusted in light of the pilot discussions. Box 10 illustrates the broad areas that were used as a platform for the main focus groups.

### **Box 10: Areas explored in the focus group discussions**

Influences on health and well being, including cultural beliefs
Communication with pharmacists and health care professionals
Consultations for minor ailments
Role of community pharmacists
New community pharmacy services
Health promotion

These themes emerged from the literature (Chapter 2 and 3) as well as the analysis from Phase 1 of the study.

### ***Stage 6: the focus group discussions***

The interview process followed similar principles described earlier in this section as

for Phase 1 interviews (Page 159). Fifty five volunteers (in total) participated. Participants were invited to come in half an hour prior to the interview for refreshments. During this time, the collection of quantitative data took place.

The focus group discussions were mainly conducted by both DN and the investigator as the researchers consulted frequently in English to make sure the researchers had understood and interpreted the conversations. Where necessary, data was back-translated almost immediately after the English interpretation was discussed. All interviews were tape recorded. The language used was the language that was understood by the participant and this meant that 'simple vocabulary' was used as much as possible. The interviews also used words in English and the interviewers made meanings as explicit and simple to encourage dialogue and be inclusive. Field note diary records/memos were also kept to capture visual behavior and observations that could be used to enhance the analysis of the data.

#### ***Stage 7: Transcribing, interpreting, reviewing, analysing and feedback***

The interviews were transcribed and translated in English. DN was critical in this process and additional help was sought from colleagues who could back- translate and verify the transcriptions. Further details of this process have been described later in this chapter.

#### ***Stage 8: Authentication and intervention***

The principal investigator was advised by DN to feedback the findings via the community centre managers. The community centre managers were used to contact participants to disseminate findings, and this process worked well, though it involved a lot of time which was not accounted for. Details of this process are described later in this chapter.

#### ***Stage 9: Evaluation and dissemination of findings***

The findings and discussion of the results are described in Chapters 6 of this thesis.

#### **Confirmation of the findings of the Phase 2 interviews**

At the end of each focus group, the researchers summarised the discussion for the participants. Any clarifications and further discussions that were not captured on tape recordings were noted in the research diary and included in the data. For follow up, focus group participants would be invited to listen to the recording of the original discussions and the key worker would present the analytical findings verbally to any

member who wished for this information. In addition the key worker also contacted key members of the focus groups as soon as the interviews were transcribed. This took place 4-8 weeks after the discussions. There were difficulties in contacting many of the original focus group members. The key worker was advised to discuss the main findings with the community centre managers if the original participants could not be contacted and /or a group could not be convened. For the Punjabi groups, DN discussed the key findings with seven of the original members of the Punjabi focus groups at the community centre where the discussions were first conducted. The investigator discussed the main findings with two members of the Hindu focus groups at Belgrave neighbourhood Centre. All the people who were contacted were satisfied with the interpretation of the results.

The manager of the community centre where the Moslem focus groups were held was contacted by the investigator as the first port of call. This was requested by all the Moslem focus group members. Prior to the telephone call about the validity of the findings, the manager of the Moslem community centre also informed the investigator that the feedback from participants was very positive and requested more sessions of this nature to be available. This was done spontaneously through an informal telephone call by the manager and was not provoked by any of the research team.

### **The principal investigator's reflections of the interview processes for Phase 2 interviews**

Focus group interviews could have been convened outside working hours to invite participants from younger age ranges. Nevertheless, the participants were enthusiastic to take part. At least ten minutes were spent prior to the interviews to break the ice and make participants feel at ease. All groups insisted on talking about GP services and the interviewers had to spend a considerable amount of time focussing the discussion points back to the research topics. Many participants from all the focus groups had personal questions regarding side effects of medicines they were taking and had queries about their personal health issues. Such questions had to be deferred until the end of the interviews. The investigator assured participants that she would address these concerns in her professional capacity after the interview was finished.

DN was from a Sikh background and the principal investigator was from a Hindu background. We both observed traditional 'South Asian' dress code during all

interviews. The investigators felt positive that this put the participants at ease. The interviews with Sikh participants were conducted in a 'Gurdhwara', a place of worship as well as a community centre, where it was important that the head was covered at all times, particularly in the presence of men. DN had advised the steering group that observing the strict cultural dress code by women was paramount for interviews to be conducted in this community setting. This aspect was instrumental to interviews with this community being a success.

The Moslem focus groups and Hindu focus groups were conducted in community centres. However, as the researchers were both non Moslems, they needed to be mindful of the dress code of keeping the hair, head and body parts fully covered. This was particularly important for the male Moslem focus groups. However, the researchers were given permission by the community centre manager that a full 'burkha' (where the full face is covered) would not be necessary.

When conducting focus group discussions with South Asian participants in their own language, the author strongly advocates the use of common 'daily' language. Both researchers believed that participants felt comfortable talking in a language that was understood. Participants opened up with their dialogue knowing that the researchers could speak their language with simple 'every day' styles, mixing different languages and dialects where necessary.

For Moslem groups, the principal languages used for the discussions included Gujarati and English. Participants also spoke Kacchhi (a dialect of Gujarati) and Gujarati and fellow participants 'interpreted' for those more comfortable speaking in Kacchhi. However, most of the interviews with the Moslem community were conducted in Gujarati and English. For Hindu groups, the participants were comfortable with Hindi, Gujarati and English. The Punjabi focus group participants spoke very little English, and the interviews were conducted predominantly in Punjabi. Initially, older members in the Punjabi and Moslem groups found it difficult to open up and proved very difficult to communicate with. There was poor understanding of issues and a lack of education and understanding of some of the very elderly participants. Many needed to be probed and in certain discussions interviewer bias was evident (for example the explanation of screening services and the role of the pharmacist). Punjabi speaking participants observed our behaviour and body language carefully before they relaxed and engaged in dialogue.

The interviews with the male Punjabi and Moslem focus groups took longer than the allocated time. The investigator concluded that future interviews with all South Asian participants which are conducted in a language other than English should be allowed extra time for 'ice breaking' exercises

Food and drink was provided for all participants. This was very well received and helped the participants to be at ease with us. It gave a chance for the researchers and participants to 'open up', and after the meal all participants wanted more of these 'discussions' and welcomed any initiatives that could provide them with relevant information. For Punjabi groups, 'Langar' (a simple home cooked meal) is available everyday at in their community settings as part of their tradition and culture). For the Moslem focus groups, the catering was organised by the community centre (halal diets were the 'norm' and this was respected). In itself the meal was very simple, as was the equivalent cost of a snack and refreshments. The meal was communal and shared from common 'pots' and the researchers were also invited to eat with their fingers. For the Hindu groups, simple vegetarian 'snacks' and refreshments were provided after the discussions.

It was during refreshments that participants highlighted certain issues that were also important to the research. Reflexive diary entries were made to capture data that were important to illustrate and enhance the results, particularly about 'de-mystifying' information about personal medication and concordance issues. This 'communal' setting amongst friends and advocates was observed to be a good way to get attention of participants who were receptive to the information and advice given.

The next section describes the analysis of the interview data.

## **SECTION 4. 4. Data analysis**

### **The principles of data analysis considered for the study**

The challenge was to make sense of massive amounts of data, manage the volume of information, identify significant patterns and construct a theory or framework for communicating the essence of what the data reveals. The investigator recognises there are different data analysis techniques that could have been used for this study. The study methodology was pluralistic, and no sole method of analysis 'fitted' the analysis criteria. The research results were to be interpreted and illustrated in a pragmatic manner to be credible and accepted by health care professionals. Qualitative studies in health care research have commonly approached 'grounded theory' analysis (Strauss & Corbin 1998) and 'framework analysis' (Ritchie & Lewis 2003).

### ***Grounded theory analysis***

Grounded theory analysis is rigorous and systemic and uses the analytical technique of 'constant comparison'. Framework analysis is increasingly used in health related research (Lacey and Luff, 2001) and was explicitly developed to specific information needs and provides outcomes and recommendations, often within a short timescale. In grounded theory analysis, data collection and analysis is done concurrently. When used in its strictest form advocated by Glaser and Strauss (Glaser and Strauss 1967), no presumptions should be made about concepts and theories prior to data collection. Open coding techniques are used to 'categorize' the data. These categories are then conceptualised, and emerging concepts are tested and compared with concepts emerging from further data collection until 'saturation' is reached with no more emerging concepts or themes. In this analysis, emerging concepts and categories can be further refined for the emergence of a core concept or theory. This emerging 'theory' can then be tested against other research or related to the main areas that affect the study, such as social, cultural and economic factors.

The investigator considered the strengths of this analysis technique. The analysis needed to be inductive for the study. As highlighted in previous chapters, the literature on this topic is sparse and in many cases controversial. The initial literature review only highlighted 'broad' areas and a fresh insight was needed to explore all the participants' views. The orthodox Glaserian (GT) approach would argue that data gathering should precede literature review: in effect, this model was followed by default, since an initial search of literature was unable to find much of immediate and obvious relevance until the key themes had emerged from the data and this informed

a more focused and effective search of prior writing. This fitted in with the 'Glaserian' approach to the analysis. However, constant comparison in its exact form was considered to be time consuming and needed to be adapted to accommodate the time constraints for the study. The literature also acknowledged that the strict coding techniques used by Glaser and Strauss were highly controversial. The emergence of a 'coding framework' advocated by Strauss and Corbin (1990) was a more favourable approach. It is also argued that the analysis then becomes 'etic' or deductive.

### ***Framework analysis***

Framework analysis shares many of the processes of grounded theory analysis (Lacey and Luff, 2001). Both types of analysis are 'emic' or 'inductive' in approach. The concept of 'comparing codes and categories' can be adapted to compare different sets of data for the emergence of categories and 'themes' to produce a conditional 'framework' to compare the different data sets. It also allows for mapping of the data from 'a priori' themes cited in the literature. The process is clarified by charting and mapping, which eases and clarifies data interpretation.

Both methods of analysis have common processes (Lacey and Luff, 2001). The processes have adapted by the principal investigator for the analysis of the data. The main steps of the analysis are illustrated in Box 11.

### **Transcription of tape recorded material**

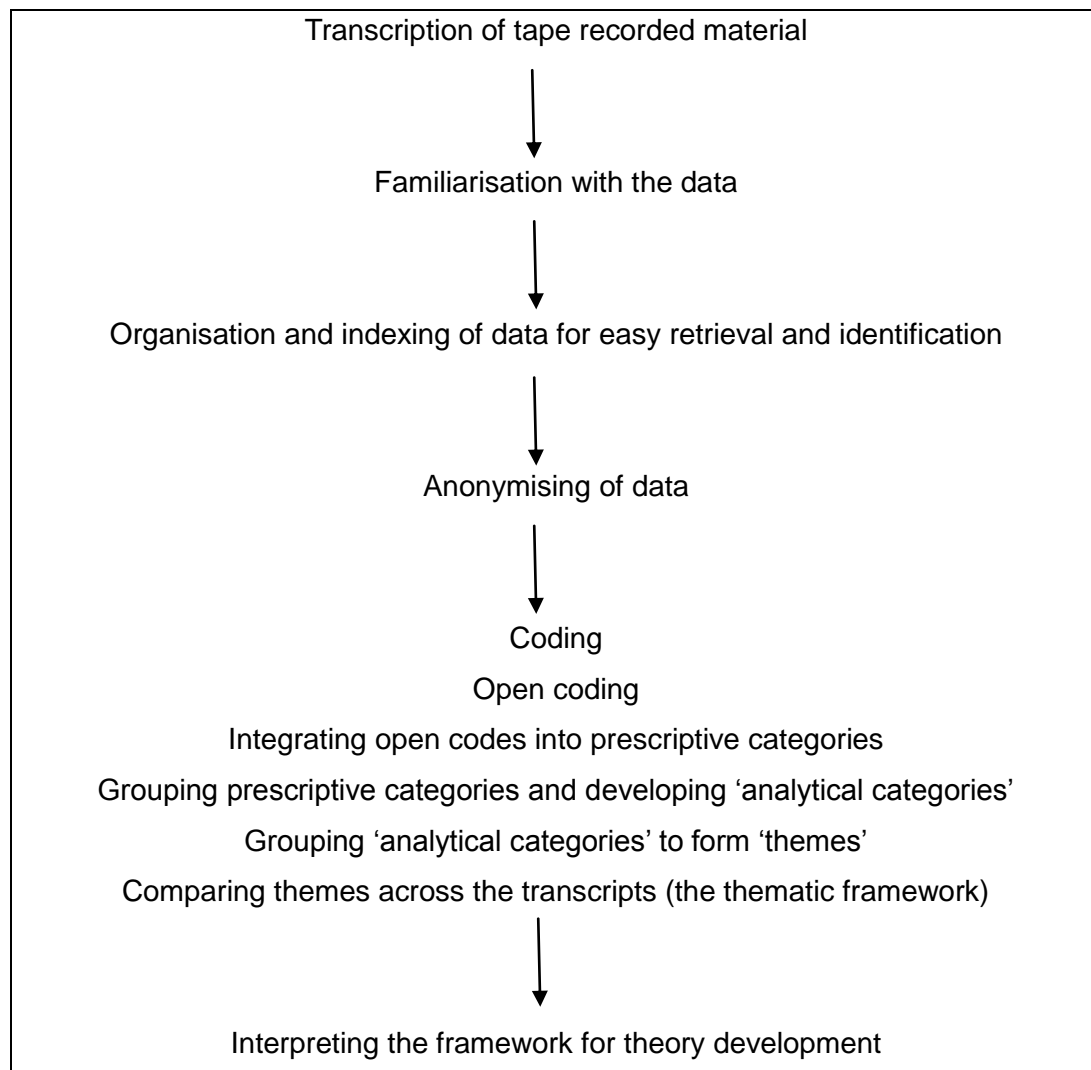
#### ***Phase 1 transcriptions***

The audio recordings from Phase 1 of the interview were transcribed by a professional transcriber who worked for the UHL hospitals in Leicester. All interviews were transcribed verbatim into Word 2000<sup>®</sup> and were checked against tapes by the investigator and the transcriber for accuracy before analysis commenced. .

#### ***Phase 2 transcriptions***

The audio recordings were translated and interpreted into English by the investigator and the keyworker DN. Large chunks of data in Gujarati and Punjabi were selected from the interviews and back translated by an independent translator for validity.

### Box 11. Summary of the main stages of data analysis



#### **Familiarisation with the data**

The principal investigator re-familiarised herself with the data after it was transcribed. Audio tape accounts were compared to the transcriptions and corrections were made after consultation with the transcriber. Field notes and diary entries that were made during the interviews were also included in the transcriptions and also used as observational data to add credibility to the research methods and the findings. These enhanced the research process and added credibility to the findings.

#### **Organisation and indexing of data for easy retrieval and identification**

The use of computer software packages to analyse qualitative data (e.g. NUDIST software) was considered but would have required time for training on the use of the software, and the investigator was constrained on resources for the use of this software. The analysis was conducted using manual techniques. Word processing



techniques of cutting and pasting, colour coding and the use of spreadsheets helped with the indexing and retrieval of data. All transcripts were highlighted by a specific colour so that during the analytical coding processes, data could be 'cut and pasted', indexed into analytical documents and the characteristics of the specific transcript easily identified. Examples of how the data and quotes were coded and indexed are illustrated throughout this section.

### **Anonymising of data**

Before analysis commenced, the principal investigator checked each transcript, stripped it of any identifying names or places. Each participant was assigned a unique identifier including both letters and numbers. This was used on interview transcripts and only the researcher could match the interviews with the participant. All data and 'data bits' were identified using these codes. The results chapter highlights the coding used to identify the interview participants.

### **Coding the data**

Qualitative researchers use 'codes' to pull together and categorize a series of otherwise discrete events, statements, and observations which they identify in the data (Charmaz, 1983: 112). Codes were used to summarize, synthesize, and sort many observations in the transcripts and reflexive diaries and memos. This became the fundamental means of developing the analysis. The coding of the data was the most time consuming process in the analysis. The following coding process was used:

**(i) Open coding.** Each interview transcript was read separately in detail then "open-coded". This meant that sentences or short contents of the text were analysed on a line-by-line basis and given a 'unit of meaning'. Words or descriptions used in the topic guides were also used as 'open code descriptors'. Initially, the process of open coding was performed by using hand written notes in the margins of each written transcription. Quotes from the transcriptions were then re-coded using basic word processing 'cut and 'paste' programmes. This exercise was repeated for each transcript. Some examples of 'open codes' and their description are illustrated below in Tables 13 and 14.

**Table 13. Some examples of the open codes generated (an example from Phase 1 analysis of GPs interviews).**

<b>Open codes/label</b>	<b>Description</b>
No routine entry on computer	Entry onto the GPs computer on ethnicity, language and cultural background
Entry for research	Entry of ethnic background of the patient onto GP system for research purposes
Usefulness of entry	Comments on whether information on ethnic background is of any use
Prescriptions for communication	Comments on whether prescriptions were issued as a means of communication, particularly where there was a language barrier or other issues.
Use of interpreters	Comments on whether interpreters were available or routinely used in a consultation, and whether they were useful or not.
Use of family members	Comments on whether family members were used for interpretation and the GPs views on this
Language barriers	Comments where not knowing the language could hinder a consultation
Telephone help lines	Comments on the use of telephone help lines for interpretation and interpreter services
Gestures for communication	Comments on how gestures as a means of communication was used
No awareness of uptake of NHS direct	No doctors commented on this
Leaflets for health promotion	Opinions on leaflets for health promotion and the views of doctors on the display
Usefulness of leaflets	Comments on whether leaflets are useful in health promotion for this community
Promotion of education	Comments on education of the public on health and education of the South Asian public on their health and self care
Leaflets and posters for communication in consultation	Do GPs use leaflets at the time of consultation i.e. pro-actively in a consultation?
Radio/media/other services for health promotion	Opinions on the use of media and other services for health promotion
Clinics in non-Asian languages	Comments on the usefulness and/or availability of clinics in Asian languages
Evaluation of use of leaflets	Do leaflets that are displayed get picked up? Is there any routine evaluation that they are of any use?
Improvements in communication and h/p activities (pictograms, labels etc)	What other ways do GPs envisage communicating with South Asian people regarding their health and medicines?

**Table 14. Grouping together similar quotes to form an ‘open category’ across GP interviews (Phase 1)**

Open code Description	Examples of Quotes (databits)
Usefulness of leaflets	<p>‘I tend to find that the leaflets are taken up more by those people that are more slightly aware of what the health issues are all about (GP 1)</p> <p>The vast majority basically uses leaflets like a play method for their kids to do it and tear pieces out of it and things like that.’ (GP 5)</p> <p>We keep dishing out literature to these people and a lot of the time we find out that it lands up in the bin or it is just thrown out. (GP 4)</p> <p>I do not think leaflets have an impact on the population in this area’ (GP 3)</p>

***(ii) Integrating open codes into ‘prescriptive’ categories***

For each transcript, the open codes were progressively focussed (grouped) into ‘prescriptive categories’. Each prescriptive ‘category’ was given a number and a ‘description’ using words which reflected the issues or ideas that interviewees said were important to them. A ‘meaning or description’ of this category was also noted so that similarities and differences could be identified and corrected. These helped the principal investigator to structure and explain how interviewees described their views and experiences to other researchers and supervisors. Sentences or ‘databits’ that could have more than one ‘meaning’ were assigned a ‘split code’ and such codes were re-examined for further clarification and meaning. It became apparent that ‘prescriptive categories’ and ‘open codes’ became more obvious in their ‘descriptions’. ‘Prescriptive’ category labels defined processes and behaviours, and open codes often had ‘abstract’ meanings which could offer a theoretical explanation. This is one of the processes in grounded theory analysis (Glaser, 1967).

**Table 15. Example of the generation of a ‘prescriptive code’. Interview with pharmacy participant 1**

Pharmacy Participant 1		
Open code number	Open Code description	Quotes (or databits)
3a	Info re cultural background and language from name	I think it would be helpful if I knew more (of how to recognize patient background from names. (1)
3b	Lack of awareness-not perceived to be a barrier	No because you can gather that information just by talking to your customer anyway, I don't personally find it a problem because you can usually gather that information by just talking to any of your patients on things like that(1).
3c	Awareness-cultural issues	I think sometimes traditional and religious issues can cause a problem with some people and affects the medication taking (1) <b>(Split with medicines compliance)</b>
3d	Awareness of alternative medicine use between white and South Asians	I may well be wrong about that but from my experience and discussions it (use of complementary therapies) is not something that I have noticed to be particularly more prevalent in the South Asian population (1) <b>(split with code for alternative /comp therapies)</b>
3e	Difference in health problems	No I don't think the problems are the same, (as white pops) I wouldn't say as a group they are any more healthier or less healthy, obviously each group has a certain spread of disease I think there are certain things which are more of a problem like weight issues and diet issues are certainly more of a issue and diabetes are probably more prevalent (1).

This exercise was applied to all the interviews and similar quotes were then grouped together. Examples are illustrated below.

**Table 16. Illustrating how a prescriptive category was built across the pharmacist interviews.**

<b>Prescriptive category no 3</b>		
<b>Description: Pharmacists knowledge/ opinions of the South Asian population</b>		
Open code number	Open description	Code Quotes (pharmacist participant identifier number)
3a	Info re cultural background and language from name	I think you take it for granted because if you can speak any other language like Hindi or Gujarati you can always recognize names and background (4) I think it would be helpful if I had more information (of how to recognize patient background from names. (1)
3b	Lack of awareness-not perceived to be a barrier	(Lack of knowledge) not a barrier (3,4) No because you can gather that information just by talking to your customer anyway, I don't personally find it a problem because you can usually gather that information by just talking to any of your patients on things like that(1).
3c	Awareness-cultural issues	I think sometimes traditional and religious issues can cause a problem with some people and affects the medication taking (1) <b>(Split with medicines compliance)</b>
3d	Awareness of alternative medicine use between white and South Asians	As far as I know, they (complementary therapies) are used, I mean complementary medicines rally up in all cultures it seems to me at the moment, but from what I have heard from patients they are used no more higher in the ethnic minority But use of alternative practitioners-yes (5)  I may well be wrong about that but from my experience and discussions it (use of complementary therapies) is not something that I have noticed to be particularly more prevalent in the South Asian population (1) <b>(split with code for alternative /comp therapies)</b>
3e	Difference in health problems	No I don't think the problems are the same, (as white pops) I wouldn't say as a group they are any more healthier or less healthy, obviously each group has a certain spread of disease I think there are certain things which are more of a problem like weight issues and diet issues are certainly more of a issue and diabetes are probably more prevalent (1).  Definitely the usual-blood pressure, heart disease, diabetes-but I cannot say by how much this is more than the normal) white population (3).....many more like this
3f	Application of knowledge of religious / cultural beliefs	I have had conversations with people before, and they have said can I have a course of antibiotics but I can't take it at such and such time in the day, or they can't take it in between these times because I am fasting, and of course because I don't have any understanding of the individual religions and traditions then I don't really understand and it would nice if I did.(2)  Participants 3,4,5 relied on own knowledge...many quotes: see spreadsheet

**(iii) Grouping categories, and developing analytical ‘themes’**

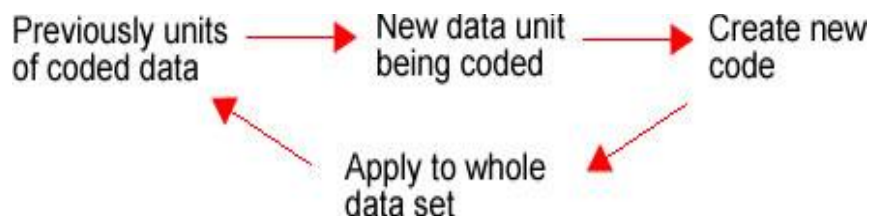
Open and prescriptive categories that had similar meanings were ‘grouped’ together to form an analytical category. Analytical categories were then grouped together to form a ‘theme’. The theme was given a code (i.e. a number) and a broad definition that best described the properties of the prescriptive codes and categories within that ‘theme’.

**Table 17. Grouping categories, and developing analytical ‘themes from Phase 2 interviews (Focus groups)**

Open / Prescriptive categories	Analytical categories	Theme code
Leaflets Video/media/newspapers Peer education NHS Direct Other tel. Help lines Computer use/IT	Health Promotion (communication)	<b>Communication</b>
Med Advice from GPs Med advice from pharmacists	Communication on medicines	
GP/Pharmacist interaction Language/interpreter needs Hospital interpreters Leaflets (as communication) Medical records in pharmacy	Communication issues (professional)	

All the data within each transcript was re-recorded with the theme codes. The following process was used.

**Figure 4: How new codes were applied to previously coded data<sup>14</sup>**



<sup>14</sup> ( from [http://onlineqda.hud.ac.uk/Intro\\_QDA/how\\_what\\_to\\_code.php](http://onlineqda.hud.ac.uk/Intro_QDA/how_what_to_code.php) accessed December 2007)

**(iv) Comparing themes across the transcripts (the thematic framework)**

A coding framework was developed using the themes from step (iii). This was applied to all the transcripts. Data was cut and pasted from the transcripts and mapped against the themes, and the themes mapped against the transcripts in a systematic manner. In this way the coding frame was continuously adjusted if data within the transcript did not reflect the theme descriptions. The framework was finalised until the point where transcripts did not provide any new themes relevant to the research focus.

Processes (iii) and (iv) are highlighted by examples illustrated in Tables 18 and 19

**Table 18. Analytical Categories from Phase 1 GP Interviews**

<b>Category (number)</b>	<b>Category label (or description)</b>
1	Information on computer (for demographics)
2	Prescriptions for communication
3	Interpreters/translators
4	Other communication issues
5	Health promotion and h/p activities
6	Improvements in patient communication
7	Doctors and staff training/knowledge of meds and cultures
8	Financial influences
9	Sociological influences
10	Barriers to consultations
11	Health seeking behaviour
12	Hot and cold medicines
13	Religious and dietary beliefs
14	Extended family influences
15	Alternative practices/medication
16	Disease states pertinent to south Asians
17	Knowledge of language
18	Shopkeeper image
19	Pharmacy Triage and Extended roles of pharmacists
20	Pharmacists training
21	Improvement in Pharmacy image
22	Promotion of the pharmacist as a health care professional
23	Education of patients
24	'Stigmatized' conditions

**Table 19: Main Themes developed from GP Interviews**

Theme 1. Role of pharmacists	Categories 18,19,20,21 and 22
Theme 2. Consultation patterns	Categories 8,9,10 11 and 16
Theme 3. Cultural influences	Categories 12,13,14,15, 17 and 24
Theme 4. Communication	Categories 2,3,4 and 5
Theme 5. Education and Training	Categories 1, 7 and 23

**Table 20. Example of a framework from Phase 2 focus groups highlighting grouping of categories and mapping across each participant set.**

Participant/ Category	Hindu female	Hindu male	Punjabi female	Punjabi male	Moslem female	Moslem male
<b>1 THEME 1: HEALTH AND INFLUENCES</b>						
<b>General health</b>	✓	✓	✓	✓	✓	✓
<b>Weather</b>	✓	✓	✓	✓	✓	✓
<b>Stress</b>	✓	✓	✓	✓	✓	✓
<b>Medicines</b>	✓	✓	✓	✓	✓	✓
<b>Sharing medicines</b>						✓
<b>Drug waste</b>						✓
<b>Diet</b>	✓	✓	✓	✓	✓	✓
<b>Lifestyle</b>	✓	✓	✓	✓	✓	✓
<b>Type of work</b>				✓		
<b>'Fate'</b>			✓	✓		
<b>Health abroad</b>	✓	✓	✓	✓		
<b>Compliance abroad</b>	✓	✓		✓		✓
<b>General perceptions of health services</b>		✓	✓			

In the next chapter, the author demonstrates the 'trustworthiness' of the data by illustrating similarities and differences of the opinions of the research participants' views. The main analytical themes and their properties are presented as a 'framework' which allows the reader to understand the research findings in a pragmatic way. The interpretation of findings of the 'analytical themes' is supported by appropriate quotes from the participants and reflective observations of the researcher.



Patterns in the categories and themes emerging from steps (ii) to (iv) were further analysed to develop a pragmatic discussion of the emerging concepts. As the themes ‘solidified’, modifications were made to the final framework to discuss and clarify the findings in a logical manner. Plausible relationships between these themes are suggested using the ways the themes co-occur within participants’ accounts in Chapter 6. The literature was consulted to gather insights which may contribute most effectively to the research focus.

### ***The properties of ‘deviant themes’***

Three aspects from the initial themes did not fit ‘neatly’ into the main framework. These were health promotion, patterns of consultation, access to services. These were analysed further and discussed with the supervisory team. It was concluded that these three areas could be discussed across the main analytical themes.

**Table 21. Final results of the coding exercise**

<b>Phase 1</b>			
	Open codes and prescriptive codes (n)	Categories (n)	Analytical themes (n)
GP interviews (n=5)	Approx 97	24	5
Pharmacist interviews (n=5)	Approx 99	22	5
<b>Phase 2</b>			
Focus groups (n=6)	Approx 286	65	6

### **Ensuring neutrality, validity and rigour in the coding and analysis**

Data from GP transcripts, pharmacist transcripts and focus group transcripts were treated as separate subsets for coding purposes. All steps of the coding exercise were undertaken by the principal investigator. During this process, the principal investigator enlisted the help of other researchers in interpreting the coding processes and themes. This process (inter-rater reliability) has been advocated (Pope and Mays, 2000) to safeguard analytical processes in qualitative research. The coding of the same data was done by other researchers as follows:

### ***For phase 1***

Steps (i), (ii) and (iii) of the coding process were repeated by one supervisor and one independent researcher

### ***For phase 2***

Steps (i), (ii) of the coding exercise were repeated by the key worker. An independent researcher repeated step (iii) of the exercise.

The coded transcripts were compared to see where there are areas of agreement and disagreement. Disagreements were then discussed and a new agreement reached about a codes definition, improving consistency and rigour. The final coding frame and theory codes were verified by the research supervisors.

### **Re-confirmation of research findings (2008)**

An opinion of some of the original participants was needed in order to authenticate the development of the discussions from the findings and also to re-confirm the findings. The principal investigator conducted three semi structured interviews between February and April 2008. A reflexive diary was used to make copious notes, observations and statements (ad verbatim) as the interviews were not taped.

### ***An interview with a GP***

The investigator interviewed one GP. This was a South Asian GP who was a previous participant from Phase 1 of the study (GP participant 5). The GP allowed 30 minutes to be interviewed.

### ***An interview with two community pharmacists.***

The investigator interviewed two community pharmacists in their workplace. One was South Asian and a previous participant (pharmacist 4) and another was a 'white' participant who worked in the same city centre setting as the previous white participants.

### ***A focus group discussion with members of the South Asian community in a community centre.***

A focus group was convened at the Belgrave Neighbourhood Centre. Eight participants agreed to be interviewed (two male and 6 female). Three participants were from the original male focus group (Hindu) used in Phase 2. The investigator was present with a moderator. The main points of the conversation were translated and copious notes were made by the researcher and then verified with the moderator.

Participants were reminded of the initial findings by re-iterating the main points from the executive summary produced for Phase 1 (Appendix 7). The findings were discussed in a thematic manner, and the process was simplified by grouping the main findings under the titles 'communication', professionalism' and 'communication'. Participants were invited to comment on the findings. The interviews were analysed as described above. The author has included reflections of the findings, supported by quotes 'ad verbatim' to support the discussions of the substantive themes in the next chapter.

All the participants concurred with the interpretation of the data. The findings from the interviews in April 2008 correlate well to the original data collection and analysis in 2005. The findings are illustrated in Chapter 6.

## **SECTION 4. 5. The limitations of the research processes**

The principal investigator acknowledges that this research is exploratory in nature and the findings cannot be generalised.

The project had finite funding and hence time and resources were a constraint. The initial design of the study was based on the requirements of the funding body, who delegated the operational supervisory responsibility to researchers from the University of Leicester. The academic supervision for the PhD was assigned to supervisors from DeMontfort University. At the best of times, the operational processes of the research were continuously adapted and the principal researcher often lost sight of the academic processes of the research. There were three changes in the supervisory team during the execution of the study. Due to unprecedented changes of the supervisory team, the research funding was exhausted, and the principal investigator had to put the research on hold so that clarifications could be made to the academic requirements of the research and further funding could be obtained. The time required for bidding for further funds for Phase 3 of the project was not anticipated.

The author recognizes that there are a number of deficiencies in the research design that could have been minimized if different approaches had been used. Different data collection methods could have been used to enhance 'triangulation' of the findings. It would be of interest in future to conduct an intervention arm (e.g. an observation study) that could have studied how community pharmacists managed patients presenting with minor ailments. Methodologies adopting the 'Roter Model' which adopts video tape analysis and methods could be used (Neal et al, 2006). This could have added more value to the research and resulted in further recommendations that could have impacted on local policy and initiatives. 'Value for money' and 'trust in community pharmacy services' could be validated by comparing the care provided by community pharmacists to that provided by other health care professionals (e.g. nurses) in a GP setting. Data collected could be used to study service users' preferences of care, how they accessed the service, whether their symptoms were dealt with in an appropriate manner and study the outcomes of the consultation. The use of patient diaries could also enhance the data collection processes and this has been highlighted in the study by Hassell et al (1999) but other researchers have highlighted difficulties with using written methods of data collection

from minority ethnic service users (e.g. Dyson, 2005). These methods were considered but the principal investigator acknowledges that South Asian service users can be very poor historians, and that data on their perceptions of minor illness may not be evident at the time of consultation. Such methods were considered for further exploration for an intervention study for Phase 3 (see Appendix 6).

This study did not set out to explore the views of the local 'white' population about community pharmacy services. Whilst the investigator acknowledges this as a limitation, she would like to repeat the current study with the same methodology and data collection tools in the white population. Additionally, nurses were not interviewed for this study and it would have been interesting to get their perspective and could have added further dimension to the study. A plethora of research has looked at the work of nurses with the South Asian ethnic minorities and, with the introduction of nurse prescribing, the views of nurses about the role of the community pharmacists and their experiences of South Asian consultations could have been valuable to this study. This was not sought due to time constraints, but is a strong recommendation for a further study.

Communication barriers have been identified in how information and advice is given to South Asian service users. More specific areas of how information and advice is given to South Asian service users could have been further explored in the interviews. Different 'scenarios' relating to minor ailments could have been illustrated where participants could have been asked to comment on how information could be given relating to particular conditions, similar to the methodology used by Greenhalgh et al (1998). The study design and the use of such scenarios in the interview schedule could have been incorporated.

The findings themselves illustrate more fundamental issues that underlie their perceptions about consulting general practitioners and community pharmacists, highlighting core issues of communication, professionalism and trust. The interviews could have explored deeper sociological and psychological issues that influence consultations for minor illness, but this could not be explored due to time constraints and would require a separate study.

It would have been interesting to look at different wards within Leicester as these different social and economic environments may have an influence on the patients' lifestyle independent of culture and throw a different perspective to this argument. It

must also be remembered that the principal investigator interviewed only a part of the vast numbers of doctors and community pharmacists in this project. It would have been more beneficial if the pharmacists and GPs were interviewed at a time outside of their working hours, with an incentive to participate. The study looked at a small sample of people from Hindu, Sikh and Moslem faiths within Leicester City. It is acknowledged that Bengali and Sri Lankan members may have added valuable insight into this project.

### **General limitations of the interview processes**

Whilst every effort was made by the researcher to be objective it would be unrealistic to suggest that the analysis of the interview transcripts has not been influenced by the principal investigator's own knowledge of cultural issues and wishes to interpret the data in a specific way. The principal investigator has standardised the process of this research by asking the same questions and allowing the same amount of time for each set of interviews. Researcher bias and the 'Hawthorne' effect cannot be discounted, though the author has addressed and acknowledged this issue at various points in the preceding sections. The minimisation of this was strongly dependent upon the principal investigator and moderator using good interpersonal skills and probing in a neutral manner and not leading the participants. The principal investigator was familiar with the interviewees in her professional capacity and this could have led to potential bias. However, the investigator has endeavoured to illustrate the interviewees' involvement in the research process and display their subjectivity and influence as appropriate. Such examples have been highlighted in the next chapter.

### **General limitations of the data analysis**

The principles of grounded theory methodology and analysis had been adapted during the coding process. 'Descriptive categories' developed in step (ii) of the process (described on Page 176) would have been discussed with the participants to get their views on the validity of the categories and how well they reflect the participants understanding of the 'reality' of their situation. Their suggestions could have been incorporated immediately, or recorded for consideration in the light of further interviews within each phase. Ideally analysis and data collection should have happened cyclically throughout the interviews so that ideas that emerged during analysis could have been explored simultaneously with further interviews. Due to time constraints, this did not always take place.

## **Summary of Chapter 4**

This chapter reflects the journey taken by the principal investigator on deciding a methodology for the project, the project design and the analysis techniques for the data.

This study was 'trans-disciplinary' straddling across the domains of sociology and pharmacy practice. The frustration of things not being 'right or scientific' with qualitative research techniques in pharmacy practice made the investigator carefully evaluate which study design to use. Choosing the methodology was an enlightening process, forcing the principal investigator to think outside her natural 'scientific', deductivist and theory testing methodological approaches. The author explored ontological, methodological principles underlying both qualitative and quantitative research methods and it became apparent that the more familiar quantitative approach would be NOT be useful to address the research question. The use of a qualitative design for the main body of the research would ensure that the research itself was more useful for policy formulation based on insights into behaviour, and also more likely to provide explanations as the researcher wished to explore feeling and opinions rather than just generate statistical information. A 'pluralistic qualitative methodology' was adopted, which used the pragmatic principles of grounded theory, ethnography, action research and hermeneutic phenomenology. Constructivist critical theorist principles underpinned the methodology whereby reality was viewed as being co-created within a contextual framework.

Opinions of GPs, pharmacists and South Asian participants were needed to gain insight into health seeking behaviours of South Asian members of the local population. GPs and pharmacists opinions were sought to gain further insight into the health seeking behaviours, patterns and barriers for the utilisation of community pharmacists and if they valued their local community pharmacists as health care advisors, particularly for minor ailments where traditionally, GPs are the first port of call. These views needed to be compared, analysed rigorously and themed so that an 'explanation' could be offered to gain further insight into their beliefs and barriers that they perceived, including cultural issues.

For Phase 1 of this study, five interviews were conducted with GPs (n=6) and community pharmacists (n=5). Participants were from both South Asian and European backgrounds. For Phase 2, six gender and religion specific focus group discussions were conducted with fifty five participants from Hindu, Sikh and Moslem

communities. The views of general practitioners and community pharmacists enriched the data obtained from the focus group participants. Semi-structured interviews were chosen as a data collection tool in Phase 1 and Phase 2 of the study. This enabled the researcher to discuss and explore complex areas and gain valuable insight surrounding the health and health beliefs of this population, including cultural influences. The method was flexible and allowed the principal investigator to gain insight into the more sensitive information on the topic. It also allowed the researcher to respond and probe issues that the interviewee describes, including ones that appear 'vague' and cannot be elicited by quantitative (or positivist) methods.

The interview environment gave participants the chance to express themselves fully and the findings could be quoted and used to illustrate the topic in the results. Semi-structured interviews also allowed for some consistency in the types of questions asked which was vital to enable any comparisons to be made between subjects when the data was analysed. The principal investigator adopted a social action research model for the focus group discussions and the involvement of a key worker and moderator for this part of the research was critical for ensuring rigour in the collection, transcription, analysis and interpretation of the data.

For the analysis, the broad principles of both 'grounded theory analysis' and 'framework analysis' techniques were adapted. The data from all the interviews was inductively coded, categorised and emerging themes were used to build a 'thematic framework'. This process was duplicated by other researchers in the steering group to ensure rigour and neutrality that appropriate steps were taken to replicate what was said and interpreted from the interviews. Any deviant cases which were contrary to the identified themes were investigated in order to take account of the issues.

The limitations emphasise the need for careful planning of the time and funding for such a study. The author has highlighted the intricacies of researching ethnic minority groups, including potential difficulties in the interview processes and recruitment of participants.

In the next two chapters, the findings of the study are illustrated and discussed. A 'thematic' approach is used.



# Chapter 5

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## **Phase 1 Findings and discussion Views of general practitioners and community pharmacists**

## CHAPTER 5. PHASE 1 FINDINGS AND DISCUSSION

### The views of general practitioners and community pharmacists

This chapter presents evidence of variations in the perceptions of general practitioners and community pharmacists about the health seeking patterns of the South Asian community, and the complexity of how GPs and community pharmacists perceive their professional roles. Their views on barriers involving communication, knowledge, cultural beliefs are presented. **(Note: Interviews were conducted between 2001 and 2002)**

This chapter is subdivided into three sections:

- **SECTION 5.1** presents findings from one to one in-depth interviews with six GPs in Leicester
- **SECTION 5.2** presents findings from one to one in depth interviews with five community pharmacists in Leicester.
- **SECTION 5.3** discusses the findings

Sections 5.1 and 5.2 begin with a description of the participants and their practice environments. This is followed by detailed descriptive findings from the interviews. Using a thematic approach, the data is supported by examples of 'quotes' or 'verbatim' transcripts, which demonstrate similarities and differences of the opinions of the participants.

The researcher has used the following interchangeable terms in the description of the findings throughout the research report and recognises the subtle differences between these terms. They include:

- South Asian participants = South Asian respondents (doctors, pharmacists and focus group participants)
- South Asian patients= South Asian service users (focus group participants)
- 'European'= 'white'

**Box 12. Objectives for GP and pharmacist interviews**

- to explore the views of local GPs and their perception of the role of a community pharmacist
- to investigate whether GPs and community pharmacists were aware of cultural beliefs of the South Asian ethnic minorities that influence (a) the consultation process and (b) the use of medicines (c) management of minor ailments
- to determine if there were any difficulties in communication with this population and methods of how these were overcome
- to determine the personal views of local community pharmacists on their professional role in meeting the needs of the local population
- to explore any incentives and barriers community pharmacists perceive in providing effective services to the local population

## **SECTION 5.1. Phase 1 Findings from GP interviews**

### ***Demographic data***

Data was collected before the interview to illustrate the demographics of the GP practices, the profile of the participants and their practice staff and this is illustrated in Table 23 (page 158).

Two female GPs (participants 2 and 5) and four male GPs (participants 1, 3, 4, 6) participated in this phase of the study. Four participants (3, 4, 5 and 6) were South Asian. Two participants (3 and 6) were Hindu and two (4 and 5: a husband and wife team) were Moslem.

Five participants (1, 3-6) had practices within Leicester City wards which have a high population of South Asians. Respondent 2 practises in Loughborough, where there is a small population of South Asians from the Bengali community.

All the participants had been practicing as general practitioners in their current practice for at least 10 years. All participants except for participants 1 and 2 spoke at least one South Asian language. All practices had GP partners and/or practice staff that spoke at least one South Asian language. None of the practices had trained interpreters on site. All practices except for respondent 3 (who was single-handed) had at least one female GP within the practice.

Participants were also asked to indicate what percentages of their practice patient population were from a South Asian background. None of the participants had defined numbers, but gave an estimated figure. This is illustrated in Table 22 (below).

**Table 22. Estimates of South Asian ethnic minority patient populations of GP practices in the study**

<b>Participant</b>	<b>% (estimated) South Asian ethnic minority patient population of practice</b>
1 (male, European)	25%
2 (female, European)	6%
3 (male, South Asian)	70%
4 (male, South Asian) and 5 (female, South Asian)	90%
6 (male, South Asian)	80%

As discussed in the previous chapter (methodology) the author has made a reflexive diary of her observations of each GP setting. I did this as so as to have a better understanding of the different 'ethnographic' settings of the interviews and that this may give me a better understanding of potential variations in the GPs' responses to the questions. The reader is invited to refer to Appendix 5 for an example of 'vignettes' from different GP settings.

**Table 23. GP Practice demographics: questionnaire analysis**

Gp code	Location	Male/ female	Length of time in general practice	Ethnicity	Religion (if from S Asian background)	Spoken S Asian language	Practice members		
							Male Drs (no from S Asian origin)	Female Drs (no from S Asian origin)	No of non medical practice staff of S Asian origin
1	LE5	M	>10 yrs	European		none	8 (1)	2(0)	1
2	LE11	F	>10yrs	European		none	3(1)	1(0)	0
3	LE4	M	>15 yrs	Indian	Hindu	Hindi, Gujerati, Urdu, Arabic and Telegu	1(1)	0	4
4	LE2	M	>15 yrs	Pakistani	Moslem	Hindi, Punjabi, Urdu	1(1)	1(1)	2
5	LE2	F							
6	LE2 and LE4	M	>15 years	Indian	Hindu	Hindi, Punjabi, Gujerati	2(2)	1	9

### **Qualitative data from GP interviews**

The aims for the GP interviews were:

- to explore their perceptions of the role of a community pharmacist
- to investigate whether they were aware of cultural beliefs of the South Asian ethnic minorities that influence (a) the consultation process and (b) the use of medicines
- to determine if there were any difficulties in communication with this population and methods of how these were overcome

Twenty four 'categories' or 'aspects' emerged from the data. These are defined in Table 24 . These categories were grouped to form five distinct themes, illustrated in Table 25.

**Table 24. Categories from GP Interviews**

<b>Categories or Aspects</b>	<b>Category label (or description)</b>
1	Information on computer (for demographics)
2	Prescriptions for communication
3	Interpreters/translators
4	Other communication issues
5	Health promotion and h/p activities
6	Improvements in patient communication
7	Doctors and staff training/knowledge of meds and cultures
8	Financial influences
9	Professional influences
10	Barriers to consultations
11	Health seeking behaviour
12	Hot and cold medicines
13	Religious and dietary beliefs
14	Extended family influences
15	Alternative practices/medication
16	Disease states pertinent to south Asians
17	Knowledge of language
18	Shopkeeper image
19	Pharmacy Triage and Extended roles of pharmacists
20	Pharmacists training
21	Improvement in Pharmacy image
22	Promotion of the pharmacist as a health care professional
23	Education of patients
24	'Stigmatized' conditions



**Table 25. Main Themes from GP Interviews**

<b>Theme 1. Role of pharmacists</b>  Categories 18,19,20,21 and 22
<b>Theme 2. Consultation patterns</b>  Categories 8,9,10 11 and 16
<b>Theme 3. Cultural influences</b>  Categories 12,13,14,15, 17 and 24
<b>Theme 4. Communication</b>  Categories 2,3,4 and 5
<b>Theme 5. Education and Training</b>  Categories 1, 7 and 23

The findings are presented as these themes and the associated categories, supported by verbatim quotes and the researcher's reflexive diary entries to substantiate and illustrate the meaning of the data.

GPs names have been anonymised and their quotes have been tagged with individual respondent numbers and ethnic backgrounds, which allows the reader to refer to Table 23 page 198 for further reference to their background.

Example: 'Quote' (GP Respondent no, E=European or 'white', SA-South Asian)

Theme 1. Role of pharmacists
<p><b>Sub-themes (categories)</b></p> <p>Shopkeeper image</p> <p>Pharmacy Triage and Extended roles of pharmacists</p> <p>Improvement in Pharmacy image</p> <p>Knowledge of Pharmacists training</p> <p>Promotion of the pharmacist as a health care professional</p>

### Shopkeeper image

All of the GPs interviewed perceived pharmacists to be 'shopkeepers' and 'dispenser of medicines'. One comment suggests how this the 'shopkeeper' image could be improved

*"Basically they all provide a standard service i.e. dishing out the medicine that we have prescribed but there is no more than that."*  
(GP 5, SA)

*'Maybe that selling a medicine over the counter doesn't bring him that much profit as dispensing the medicine through a prescription'*  
(GP 4 SA)

*'I think a pharmacist should always be a pharmacy not selling newspapers and chocolates'* (GP 3, SA)

One of the barriers to teamwork identified was because of this 'image' and the perception of a 'commercial collusion' rather than a 'team' providing cohesive advice. The concept of a 'commercial gain' was mentioned, adding to the debate of the pharmacy as a 'business' rather than a professional service. However there was a difference between how a 'white' GP and a South Asian GP viewed this concept. The 'white' GP was cautious about commenting on this because they were unclear of the processes that would enable GPs to allow the pharmacist to carry out a 'professional' service without extricating this from the 'business' element.

*'I don't think you could have a specific pharmacist from a specific chemist who is designated to be useful within the practice.'*  
*'Although we work closely with our pharmacist and chemist next door its seen as a sort of commercial thing and there has been barriers with doctors colluding with specific pharmacists so that stops you forming a real genuine team'* (GP2, E)

*'If a pharmacist is attached to doctors premises or within the premises if he (the doctor) doesn't write something on a prescription or if you (the patient) are refused a prescription or if you (the pharmacist) overwrite a prescription they (the patients) think it is a (commercial) deal going on.'* (GP 3, SA)

The 'shopkeeper' image was also commented on when GPs were probed on their knowledge of the training of pharmacists and if this 'image' could be further dispelled by GPs helping in the promotion of the role of the pharmacists as a health advisor (see below). GPs also argued that the benefits of co-location of pharmacy premises on the same site as GP practices would have to be demonstrated beyond that of a more 'commercial' status. This has been endorsed in the wider literature (Hassell and Wilson, 2003; Ford and Jones; 1995). Jesson (2002) comments that co-location offers opportunities but that there are barriers linked to the loss of traditional commercial activity. The recent review by Darzi (DH 2008c) endorses the idea of 'services under one roof', but does not make any specific recommendations for community pharmacy services.

### **Pharmacy 'triage' and extended role of the pharmacist**

Most GPs had little or very limited knowledge of the pharmacist's 'extended roles' and the new Government initiatives. The principal investigator was invited to explain the main proposals of the Pharmacy White paper (DH, 2000b) to the participants!

The concept of 'pharmacy triage' (i.e. a pharmacist being based within a GPs surgery akin to a practice nurse) and other 'extended' roles envisaged in the White paper were explored. In principle, some GPs were very positive about these initiatives and commented on how pharmacists themselves would accept their 'extended' roles providing services other than dispensing.

*'I think it would be very helpful. There is no need to come to the doctor for a lot of things that they would necessarily come bringing their children in for recurrent pyrexia (raised temperature) very often... there is no reason why a pharmacist shouldn't be able to give them reasonable advice'* (GP 1, E)

*I think it is a very good concept-the more health professionals involved the better because of the educational component. I know we constantly keep reading about this thing that the extended role of the pharmacist is going to be introduced which is good for the profession as a whole and I'm sure that this is a step in the right direction because they could reduce the pressure on the GPs and we hope that if a lot of people start to go to the pharmacist for treatment of their trivial illnesses it will help doctors a great deal.'* (GP 4, SA)

*I would not see it as a threatening role I would see that as a complementary for me because basically that is reducing my workload rather than me have to do that. (GP 5, SA)*

GPs commented how such 'extended' services would be perceived by pharmacists and commented on the importance of 'trust' in the services being an important aspect of their patient's perception of pharmacists in an 'extended' role. GPs were also cautious to comment as they thought that promotion of minor ailment schemes had to be carefully designed to ensure that the scheme was 'fit for purpose' as this could affect the 'business' elements of the community pharmacy.

*'How would the pharmacist perceive that? Wouldn't that undermine your role in the sense you are just doing this (extended services) as 'extra' but your prime role is to dispense and sell medication as well.' (GP 5, SA)*

*'I think it (the 'extended' service) would be more likely to be taken up if it was more actively promoted depending on the views of the community pharmacists as well whether they are interested-what about the business side?' (GP 1, E)*

In contrast, a comment from another GP illustrated an interesting aspect to the 'triage' and extended role being perceived as a 'threat' to the more traditional roles of other health care professionals (e.g. nurses).

*'That's not to say that the interest is not there the interest has been there because I know one or two pharmacists have come to me when the government was trying to set everything up in house and the pharmacists were very keen to take that on board and to provide their services for consultation purposes. But I think there was a bit of a political thing there with some people; some doctors thought that their jobs would be threatened' (GP4, SA)*

This concept is also explored with community pharmacists in the next section of this chapter.

### **Improvement in the pharmacy image**

Several GPs commented on various ways that existing community pharmacy services could be best utilised for 'extended' roles. Privacy was considered an issue, and 'registration' of patients with one pharmacy (similar to GP services) was considered to be an option.

*'I still welcome that that where pharmacists would offer services for basic consultations and provide say a small consulting room in their pharmacy for small problems. This will just make it a lot more sort of tidy and with specific advertising as well saying we do provide this*

*service if you want to see a pharmacist privately there is a procedure to do so.’ (GP 5, SA)*

*‘Patients that are registered with me need to be registered with one pharmacy instead of using any pharmacy. At least we can pin point ok this is a place, this pharmacy is responsible for this patient and if there is some problem we can always follow it up whereas at the moment we can’t.’ (GP 3, SA)*

The notion of trust and the ‘professional’ relationship with patients was mentioned by all the GPs to be one of the key factors that they considered would be accepted by service users, and indicated that once a good relationship was formed, patients could perhaps be directed to appropriate services.

*Triage and extra services can be like additional session yes certainly. You are discovering a lot along the lines of what we have at the moment in nurse practitioners they have similar roles and a lot of the patients perceive the nurse practitioner as a doctor rather than just the nurse..... at the end of the day these patients don’t know very much about the status of people what they are concerned about is somebody to trust and somebody they can relate to and give them good advice and something that will work for them and that is all there is to it and if you can do and guide them along the right lines they will hail you as the next hero’ (GP3, SA)*

However, as the interviews progressed, GPs admitted to having very limited knowledge regarding the practical and academic training pharmacists receive.

*‘I really am not aware of the pharmacists role today (GP 5, SA)*

*‘They (South Asians) think pharmacists just give tablets and that they don’t know anything about how medicines actually work.’ (GP4, SA)*

They also commented that South Asians needed to be educated more about the pharmacists role as a health care professional if they wanted their image to be perceived as that other than a shopkeeper.

*‘They (the patients) should be educated that the pharmacist is not a shopkeeper and this is where we have all got to contribute to that.’ (GP 3, SA)*

*I feel personally because they (the patients) don’t think that a pharmacist has studied four years or five years. They think (pharmacists) dish out the tablets and (pharmacists) have no idea about the illnesses (GP5, SA)*

These themes were also explored with community pharmacists and South Asians participants in this study.

### **Promotion of the pharmacist as a health care professional**

GPs were specifically asked if they encouraged patients to use community pharmacists as health care advisors to patients during a consultation. There were many disparate comments and all the GPs interviewed found it difficult to give a direct answer. Many had to be probed, and there were many 'defensive' comments made about the education of the South Asian community not being 'educated' to understand the role of the pharmacist, making it difficult for the GP to do the 'education' role during the consultation.

All the participants were able to discuss what they thought of the current role of the community pharmacist. There were perceptions of a 'traditional role' and of 'mechanistic referral' to have a prescription dispensed.

*'Very rarely do I send somebody to go to a chemist apart from giving them a prescription' (GP 1, E)*

They commented that their patients may have already been to the pharmacist before consulting them but the patient was not routinely questioned whether or not they had seen a pharmacist prior to the consultation. GPs indicated that this was not unique to South Asian ethnic minority patients.

*By the time they have got to me, the opportunity to go to the pharmacist has gone in a way. (GP2, E).*

The role of the pharmacist was not actively promoted by any of the GPs. Some said that if the role was promoted effectively it might have some impact on how the services were perceived. All GPs acknowledged that they could help raise awareness of the pharmacist's role. GPs also questioned how their patients would perceive the potential 'education' of the role of the community pharmacist for giving advice about minor ailments. All GPs commented that the 'shopkeeper image' needed to be dispelled. This needed targeted education and promotion strategies.

*'They (the patients) are not educated, this is where we are lacking behind, and they should be informed this is a line of contact, not the doctor immediately for minor things' (GP3, SA)*

*'If they can accept the information on promotion of the role of pharmacists more readily from us then it would be reasonable to promote it' (GP1, E)*

This aspect of the findings illustrated that there is not only a clear requirement for the improvement in professional collaboration between GPs and community pharmacists,

but also a need to improve the knowledge of the community pharmacist's professional roles and responsibilities to other members of the primary health care team. Although the study sample for this phase study was small, the findings show considerable lack of inter-professional collaboration and communication between GPs and community pharmacists. The findings from the community pharmacy interviews (page 236) will also illustrate this point. This is confounded by the lack of GPs knowledge of the community pharmacists' education and training. In the next section, interview findings about consultation patterns give a further insight whether such inferences are unique to the South Asian population.

Theme 2. Consultation patterns
<p><b>Sub themes (categories)</b></p> <p>Knowledge of diseases pertinent to South Asians</p> <p>Influences on health seeking behaviour and minor ailment consultations</p> <p>Financial influences (including cost of medication)</p> <p>Professional influences</p> <p>Barriers to consultations</p>

### Knowledge of diseases pertinent to South Asians

All the GPs interviewed were aware of particular disease states that were prevalent in the S Asian ethnic minorities (e.g. CHD, diabetes, and certain vitamin deficiency states). One respondent went into a lot more detail about disease states more specific to certain sub-groups of South Asian people and this was from his own knowledge.

*'If somebody is from lets say western Gujarat, or western part of India for example most people from that area believe in certain food habits, certain medication they don't take compared to a south Indian which is more of a mixed diet population, there are variable factors we get more people, lets say for example B12 deficiency coming from that part of India compared to southern part of India.'*  
(GP 3, SA)

### Health seeking behaviour and minor ailment consultations

All GPs indicated that members of the South Asian population consulted frequently for minor illnesses (viral illnesses, coughs and colds).

*Very often they (South Asians) seem to come with children who have recurrent fevers and viral infections and that seems to worry them.* (GP 1, E)

*Most consultations are for minor illnesses, (GP3, SA)*

GPs were further probed on minor ailment consultations. There is considerable overlap in the categories within this theme, and also with the comments obtained in Theme 1. The reader is invited to consider the quotes in this category alongside the



quotes cited above. Two European GPs and one Asian GP made interesting comments about how they perceived South Asians 'minor' illness consultations.

*'It's just their (South Asians') perception (of illness) and acceptance of what is wrong that seems to be the difference (between South Asian and 'white' patients). ' (GP 1, E)*

*'I don't think they (South Asians) necessarily consult more with their minor ailments but the consultations they do make are more likely to be for minor ailments because they won't necessarily come in for the more chronic diseases.' (GP 2, E)*

*'They (South Asians) will come here at the first sign of a sneeze and they will expect medication and I think that is where the difference lies, Asians want medication rather than just advice, if you fob them off with advice they think that you have not done a service.' (GP 5, SA)*

Cost of medicines, particularly of over-the-counter medications and prescription charges was cited as one of the reasons for South Asian patients to go to a GP as the first port of call, particularly for minor ailments. Many patients go to a GP for a prescription as they may be exempt from paying prescription charges. This also influences the likelihood of GPs referring patients to a pharmacist. All GPs commented that that this might influence consultation patterns (see theme 3).

*'I think part of it is to do with the payment of prescriptions because a lot of our Asian patients are on repeat prescriptions so it is advantageous to come to the doctors to get the prescription even if it is Sudafed, so they are not going to go to the pharmacist because they would have to pay.' (GP 2, E)*

*'To a very large extent still we find that the Asian community is very reluctant to buy medicines over the counter because of cost.' (GP 4, SA)*

*'There is an incentive because they know if they get something from the doctor they don't need to pay for it.' (GP 2, E)*

*'If it is during working hours they have a choice to come here or go to you (the pharmacist) they will come here because the prescription will not cost them anything. 80% of the people they will not pay. (GP 5, SA)*

Prescriptions were issued to overcome cost barriers of the patient having to pay for medication that could be bought over the counter.

*'Because we deal with the sort of population which are socially poor and on low incomes they expect all their medicines should be free. If they go to their doctor to get Calpol® they won't have to pay for it so they're much more reluctant to get them from the chemist and I think cost is a factor.'* (GP5, SA)

The underlying sociological need for South Asians to consult GPs is well documented as literature does illustrate that South Asians consult GPs more frequently than the 'white' population (e.g. Gillam et al, 1989; Gill et al; 1995, Rashid and Jagger, 1996, Cooper et al, 1998). This included the expectation of 'free prescriptions' because of the patient's social circumstances and the financial costs of purchasing over-the-counter medication. Disparity (lack of homogeneity) between the ways GPs practice and perceive these issues was interesting to observe in the interviews.

*'If we refuse to give the medicine they call the emergency services and the emergency service has become something of a culture again, National Health Service culture they think one doctor is not able to give the medicine they will get another doctor who will dish out the prescription.'* (GP4, SA)

*I have an example of a patient who came to see me the other day who had a viral respiratory infection and when I suggested that they didn't require a prescription the actual quote was that 'I've been waiting half an hour but you're not going to give me anything. My previous Asian GP always used to give me something.'* (GP1, E)

Some GPs did comment that some patients sought appointments in order to get a prescription. South Asian GPs were openly forthcoming about this issue and the 'pressures' they had from patients to issue them with a prescription for medicines which they could use for possible exacerbations of symptoms.

*'When you don't want to write a prescription the first person he will say I waited for an appointment for five days now you refuse a prescription, if I have got to see you again it will take another five days so the doctor lets him off with a prescription, whether they need it or not it is to satisfy his own interest.'* (GP 3, SA)

*'Some of these habits (the issue of prescriptions for minor ailment medicines without the clinical need ) have become more common because of the reason that somebody somewhere is just dishing out prescriptions so they always cite examples Dr A or Dr B or Dr C is giving prescriptions why can't you write one. People hear about these things, Dr A is no good he doesn't give medicines, Dr B is very good you ask him for 50 tablets he will give you 100, and it has been going on for a long time (GP5, SA) together with comment*

*'Some people are willing to prescribe drugs because they don't want to lose the patient'* (GP 4, SA)

In contrast another South Asian GP comments that the 'expectation' of a prescription by patients can be better managed with the building of 'trust' and professional relationships. When GPs were asked whether South Asians appeared to consult them more frequently for minor ailments, the perceptions of 'white' GPs and South Asian GPs varied. 'White' GPs commented on the idea that many patients, not just from South Asian communities, consulted them for 're-assurance'. South Asian GPs further re-iterated the notion of 'trust'. The reliance on consulting the GP for 're-assurance' by way of a diagnosis was an interesting finding from the perspective of 'white' GPs, who also commented that this may not be 'unique' to the South Asian population.

*'I wouldn't be at all surprised to find that a lot of our S Asian or ethnic populations are so quiet in terms of that they don't come at all perhaps. The ones that do come to you sometimes wonder whether they do come in fairly frequently.....Very often the diagnosis is a viral illness and reassurance is all that is required. But you do find that certain groups of people seem to come back quite frequently.....For reassurance I think. 'It's just their perception and acceptance of what is wrong that seems to be the difference' (GP 1, E)*

*They (South Asians) think that the GP will probably will give them the right advice compared to the pharmacist because they believe in (the GPs) professionalism much more and they think that he is the right person who can tackle their problem' (GP 4, SA)*

*'It takes a bit of trust. Once they gain your trust, they have faith in you. When you have done an examination and say look you don't need any antibiotics, you don't need any prescriptions or anything, give it time and we'll see how it goes, and they have to go away with that advice. But it won't work with any doctor they have to basically form that trust. What they are concerned about is somebody to trust and somebody they can relate to and give them good advice and something that will work for them' (GP 5, SA)*

These findings correlate well to the study by Morris, Cantrill et al (2001b) with 'white' patients, which showed that GPs were clearly frustrated by the level of minor ailment consultations and that there were more complex reasons which influenced their attitudes. The need for measurement of blood pressure and an 'examination' seems to be more 'exaggerated' as need for South Asian patients, but is not 'unique' to this population and warrants further exploration. The issue of a 'diagnosis and the notion of 'reassurance' was also observed in the study by Whittington et al (2001b) who showed that patients would use a 'minor ailment referral scheme' if they had a clear understanding of their illness and its treatment, and that patients in that study who presented with more overt symptoms such as earache, coughs, sore throats and a

combination of these were more likely to consult a GP. Most GP and pharmacy participants discussed the point that cost barriers were important in minor ailment consultation patterns and the uptake of minor ailment schemes envisaged in the White papers (DH 2000b, 2003b) and this finding also correlates well to the literature. The study by Gill et al (1997) refutes the belief that Asian doctors prescribing practices are different to their 'white' counterparts. In the author's opinion, sociological and psychological implications would also need to be considered and such health behaviour models and approaches would need to be appraised before any meaningful conclusions can be made, and the literature also re-iterates this observation (Webster, 1997; Hibbert et al, 2002; Webster et al, 2002).

### **Barriers to GP consultations**

Two participants commented that members of the South Asian population liked the concept of physical monitoring e.g. blood pressure monitoring regardless of the condition they have that might warrant a clinical measurement or investigation. It appeared that some consultations end up in patient referrals for investigation due to patient pressures on the GP and for the consultation to have an amicable outcome.

*'They clog up our surgeries by using it for attendances that are unnecessary and demand investigations, which they have had'.  
(GP4, SA)*

Additionally, GPs also commented that South Asian patients seemed to be more 'satisfied' when they had somatic symptoms 'investigated' by means of having their blood pressure taken, or their chest examined.

*'They (South Asians) love their blood pressure being monitored, never mind about the fact that they have got diabetes or coronary heart disease, but if they can see something physically being measured they seem to take a far more keen interest because they can see some physical improvement if there is any, after doing measurements' (GP2, E) (from Interviewers reflexive diary observations).*

The author also notes that GP5 (SA) commented that South Asian patients often consult with family members, including children. She commented that it although it was mainly for communication, it could also be for re-assurance. There is also a 'cultural' aspect to consulting with family members (from Author's reflexive diary). Examples of comments from other GPs are illustrated under Theme 3 and Theme 4.

Two participants commented that appointments affected the frequency of consultations. Attendance by South Asian patients with family members was also cited to be an important psychological factor for re-assurance during a consultation. One GP stated that it would be beneficial if pharmacists were consulted before the visit as it would possibly overcome the need for an appointment system. Most Asian GP participants also alluded that this population consult for 'multiple' problems.

*'They don't still understand the concept of a consultation is for one or two problems not multiple problems. (GP 3, SA)*

*'Very common practice, that the mother will make an appointment for a child so when they come in they will bring two or three other children and they will end up having consultation about their own problem and the other children's problems and they want to have medicine written for the other children which is a fairly common practice with the Asians. It is something we do not like but we have to comply for the sake of avoiding another appointment coming up later on. (GP4, SA)*

*'I think a lot of the Asian patients would find it easier because you haven't got the barrier of making appointments' this might be better in access barriers (GP1, E)*

Some GPs commented that they can take a longer time with South Asian patients in a consultation and that this impacts on the 'quality' of the consultation. The time required for a consultation also relates to the theme of communication (illustrated later in this chapter) and that more time could be required due to other influences (see below). It was interesting to note that the 'white' GPs needed to 'manage patients' expectations' for a prescription and that this needed more time. These GPs also commented that more time was required in a consultation to educate patients, and that there was an 'assumption' that the pharmacist would do this.

*'We sometimes do not have that time to effectively spend with them. I do think it is important for this group.' (GP 2, E)*

*I think that any patient who comes in with a clear idea that they want a prescription and if you are not going to give them a prescription.....then you are going to take more time with them.....I don't think it is just more peculiar to ethnic minorities' (GP 1, E)*

*By the time the patient has come in to you with a relatively trivial problem what you are trying to do is get them dealt with as quickly as possible and in those sort of circumstances there is a disincentive to spend the extra time doing the educational element, the best you could probably hope for is the pharmacist could probably advise the patient about such issues.' (GP 2, E)*

Some GPs raised interesting observations on how members of the South Asian population perceive the NHS. Rates of consultation were also affected by lack of patient education regarding the understanding of the basic functions of the GP services within the NHS.

*'They will sit on their illness; they will say 'as soon as I am in England I will go and see my doctor I will have a free consultation and a free treatment'. This is the greatest misuse of the health service.'* (GP 4, SA)

*'I think when the ethnic minority came to this country and when the new GP's also came at that same time it was a question of numbers, who gets what. I think that was the time when the government should have really taught everybody what NHS is and how it should be used. I think they were just misled into using it for every purpose, thinking a prescription is a must and keeping everybody happy'* (GP 3, SA)

*'They are under the impression it (the NHS service) is free, the consultation is free the medicine is free and they don't mind going to the doctor a hundred times during the year'* (GP 5, SA)

Communication barriers to consultations were also commented on and are discussed separately in Theme 4.

Theme 3. Awareness of cultural influences and sensitivities
<p><b>Sub-themes (categories)</b></p> <p>Religious beliefs and diet</p> <p>Alternative practices/medication</p> <p>Hot and cold medicines</p> <p>Extended family influences</p> <p>Stigmatized conditions (mental health problems, contraception)</p>

### Religious beliefs and diet

All the GP participants had knowledge about the Fast of Ramadan (in the Moslem religion). They commented on the fact that this may cause problems of compliance but the South Asian GPs were more aware of how the problem could be rectified. Examples of diabetic control being affected and of specific fasts and dietary habits that could lead to potential problems were identified by all the GPs. Inclusion of specific ingredients such as pork, beef, gelatine and alcohol in medicines were cited as specific examples of dietary issues that could be a problem for this population. Four South Asian GPs identified information on more specific areas such as the chewing of betel nut and the use of kohl pencils, although this was based on the personal knowledge and experience of the GPs.

*'Well you basically try to re alter their regime of their tablets. On the whole Ramadan is very anti diabetic. And then you have got the flip side of the coin with the Hindus who will not entertain even eating eggs and they are deficient in things like B12 and Vitamin D and they are proud to tell you that they are strict vegetarian with a smile on their face and they are happy to take injections. (GP 5, SA who is Hindu)*

*'If you give them something if it's not quite agreeable with their religious beliefs then they won't comply with the medicines'. (GP 5, SA, Moslem)*

*'I haven't found it a big problem.... as I can say that there seem to be let out clauses if you like that enables them to take certain things' (GP 1, SA Hindu)*

*'I think as a drug whatever they got diabetes, hypertension, asthmatic I have found that I have to start all over again when they come off because some of them they keep taking the drugs and some of them do know how much they should be taking before the*

*strict fasting times in the morning and evening but some of them don't and then you have to really sort them out when they come back after Ramzan (Ramadan)' (GP 4, SA Moslem)*

### **Alternative practices/medication**

All Asian GP participants were aware of consultations with 'alternative' practitioners (hakims, vahids etc) both in the UK and abroad. It was thought that these consultations were mainly for a 'reassurance' or a 'second opinion'.

*'The problem arises when they go to a traditional herbalist hakims, and the potions and mixtures that they give them you don't know what is in them and whether that will interact with the medicines I have given them and that could be a possibility and that is always a problem.'* (GP 5, SA, Moslem)

*It would be useful to know what their beliefs are and what other treatments they might be having. In some cases they may be getting alternative therapies which could interact with perhaps what we're trying to do them in terms of medication (GP 1, E)*

The information on the use of non-allopathic medicine and practitioners is not routinely volunteered by patients and is only divulged if the GP enquires explicitly. It appeared that GPs are reluctant about asking for information because of their lack of knowledge of these practices and they were not sure whether they could provoke an honest response from the patient.

*'I don't think they do actually (tell Dr about taking other medications).....that can be quite frustrating....firstly because you don't know quite what they're doing outside of conventional medicine. (GP 1, E)*

*'This is because they don't want the doctor to know what other substances they have been using so that their treatment will be stopped and the doctor will be very cross with them.'*  
(GP4, SA, Moslem)

Pharmacists and South Asian focus group participants were also questioned about these issues.

### **Hot and cold medicines/beliefs**

When probed about 'hot and cold' beliefs the responses and interpretations were disparate and subjective. Two Asian GPs alluded to the fact that this was a 'literal' translation of the action of the drugs or their side effects.

*'I'm not quite sure what this hot and cold means its more western interpretation of what Indians tend to refer as something that is 'hot'*



*for them. If you interpret it literally then I think you are going to lose the meaning of it but I think if a medicine does not agree with them, say if you give them ibuprofen and it causes a bit of stomach upset or it causes severe gastritis, they will come back and say this medicine was very hot for me meaning that it produced a side affect..... not necessarily that it caused some imbalance of energy, it is their way of saying that it cause a side effect.’ (GP 5, SA and GP4, SA combined comments)*

*‘Its anywhere, you go to any south Asian country, they talk that way about hot and cold ‘effects’ but then it is not very significant’ (GP 3, SA).*

The ‘white’ GPs could not comment on this as they had not heard about this concept, and the ‘white’ pharmacists were also probed about this issue in later interviews.

### **Extended family and other community influences**

GPs were invited to comment if they had observed any differences in attitudes in health between generations and if this affected the beliefs of the ‘extended family’. Education of all the family members ‘from the beginning’ was cited as being important as it is the ‘habits’ that are passed from generation to generation that influence people’s perception of health. This was however, not seen to be unique in this particular population.

*‘A lot of the young (South Asian) mothers they still are being ‘hassled’ by their mother in laws.’ (GP5, SA)*

*‘Depends on what type of background they come from. If they come from a background where the parents have been using the doctors all their life because they have been visiting the doctor with their mother they have learned, it is a learned behaviour from the parents. The mother keeps on telling them you should go and see the doctor because anxious mother makes them anxious children and they do come to us’. (GP4, SA)*

### **‘Stigmatised’ conditions**

GPs described that ‘stigmatised’ problems e.g. depression needed to be ‘probed’ out of the patients and they described the differences between South Asians and ‘white’ patients in the expression of such symptoms. There were other confounding references to communication, the lack of appropriate counselling services and that the presentation of depression was often in the form of overt symptoms that could be for a ‘minor’ ailment. This aspect is also explored with the Pharmacists and South Asian focus groups to probe for more ‘cultural’ influences that could help understand this issue. GPs in this study said that South Asian patients often consult for

'multiple' problems. They also commented that South Asian ethnic minority members are 'very poor historians' (i.e. give a poorly presented personal history of the illness) often presenting with symptoms not necessarily related to the underlying cause of the problem. For this reason, they commented that it can be difficult to diagnose mental illness and that more time is needed in a consultation to get to the 'root cause of the problem'.

*'Asians tend to find it difficult to present that way (i.e. with mental health problems), they don't open up, you have to literally dig, and they are very poor historians. You are not just dealing with your normal run of the mill English patients and therefore communication is not a problem and they much better historians and their more specific to the point and do not present multiple problems, all these things you see with Asian patients, they put emphasis on the wrong things when the real problem is somewhere else' (GP 5, SA)*

*'You get a lot of particularly women, who will come in with lots of physical ailments and I know that if I could communicate better with them that I would come to a diagnosis that they are depressed. My gut feeling is that they are depressed and that they need treatment of anti depressants or counselling, but that whole line of treatment, particularly the talking therapy is just out of bounds in a way because we have got no way of providing it.' (GP1, E)*

*'I think you keep on exploring until they definitely come out with the hidden agenda. (GP3, SA)*

Some GPs commented that female patients were generally more anxious and not very open during a consultation.

*'The female patients I feel personally are more anxious about their health problems. There is something also which probably continues this thing that female patients are probably neglected at home they cannot communicate with their husbands and children and therefore they find refuge in going to the doctor and in some instances we have found that ladies just come here to chat and spend time but by and large I feel that the problems are much more amongst the ladies than they are in men'. (GP 5, SA)*

It was interesting to note that 'presenting' symptoms could be interpreted as 'minor' symptoms but could 'mask' an underlying psychological or therapeutic problem, and that unless adequate time was given during the consultation, these conditions could be missed. When probed further, such behaviour was explained in relation to minor ailments.

*Most of them then present me with just with minor illnesses with a hidden agenda ready to be asked. **Probed to elaborate:** They tell*

*us about headaches and that they cannot sleep, more observed symptoms such as a bit of pain and in the time we have all that is explained by the patient is that it is a 'small' problem and are happy with a prescription for paracetamol. They do not open up very easily. (GP 3, SA)*

The issue of contraception is illustrated by two GPs, one European and one Asian which shows the sensitivity of cultural influences

*'It is much more effective if a woman comes in with a female patient who comes in, I find that when men are interpreting I can tell from the body language that the man is not telling me what the woman is actually saying. It's usually with the chronic illnesses or issues like contraception, I mean see a lot of the ladies for family planning and I find that that is when the men are interpreting things differently because the man is saying that everything is fine and you can see that the woman does not want to have another baby just yet, she wants to have some form of contraception, but I am not being able to converse directly with the patient and there is a conflict of interest there. I am not sure if that strictly is cultural I think it appears so because most of the Caucasian (European) women do not come in with their partner and perhaps if the partner was there we would get the same problem but because the cultural differences with the Asian ladies if they don't speak English or if their husband feels he should come with her he tends to take over the consultation so you are not really dealing with the patient, you are dealing with the husband'. (GP 2, E)*

*'Contraception its one of the most difficult things among Asian women and you do find that a problem. The women want the contraception but the men do not allow this'. (GP 4, SA)*

Such 'stigmatised' issues were also discussed with South Asian focus group participants in subsequent interviews, and other conditions that were considered to be 'stigmatising' were discussed.

GPs were asked whether female South Asian patients followed different consultation patterns, particularly if they sought consultations with female GPs and if this was influenced by their cultural or religious beliefs. Some GPs commented that female patients consulted doctors of either sex but would show preference for a female doctor if given the choice. If there were no female doctors in the practice it would not deter female patients from consulting.

## Theme 4. Communication

### **Sub- themes (categories)**

Health promotion and related activities

Use of leaflets

Interpreters/translators

Other communication methods

Prescriptions for communication

Improvements for patient communication

### **Health promotion and related activities**

Information leaflets (translated or otherwise) were not pro-actively used in a consultation but thought it would be useful to use them at the time of consultation. Four GPs did not think that leaflets were read. Education of the patient influenced whether leaflets were actually read.

*In terms of giving someone a leaflet I'm not sure how effective they are without actually going through it with them as well and explaining it to them' (GP 1, E)*

*'I tend to find that the leaflets are taken up more by those people that are more slightly aware of what the health issues are all about, people that are a bit more knowledgeable people that are more educated (GP2, E)*

*'The vast majority basically uses leaflets like a play method for their kids to do it and tear pieces out of it and things like that.' (GP 5, SA)*

*We keep dishing out literature to these people and a lot of the time we find out that it lands up in the bin or it is just thrown out. (GP 4, SA)*

Concerns were raised about the level of information in the leaflets as many members of this population could not read or write their own language let alone English.

*Certainly ones that are illiterate and have no command of the English language will not even look at those leaflets. You have to prompt them (GP2, E)*

*'Whatever literature we could get in last six months we have distributed it among that population. Most of it has come in English and half of them they can't read English.' (GP 3, SA)*

Time constraints prevented pharmacists and GPs to go through appropriate leaflets with the patient at the time of the consultation, and there was an 'assumption' by GPs that the pharmacists would do the 'education' element. The use of community

initiatives for health promotion was welcomed by GPs, but the idea of community initiatives was not forthcoming during interviews with pharmacists.

### ***Interpreters/translators***

Official interpreter and/or translator services were not routinely used by any of the participants. Four Asian participants spoke two or more South Asian languages and had no need for any interpreters. At the time of the interviews four practices had at least one Asian member of staff (apart from any GPs) who could be called upon for translation purposes. One 'white' GP was aware of the availability of official interpreter services and, if needed, patients were made aware of the use of these services at the time of booking an appointment. They were also informed that they could use one of the reception staff or bring family or friends to interpret for them. It was interesting to note that all the GPs were sceptical of using interpreters. There were some concerns about the training and/or the availability of interpreters. Most were concerned about holding a consultation with interpreters as their medical training did not cover this aspect.

*'I think it is always going to be less effective talking through an interpreter. Partly I think that is because we are not skilled at talking through interpreters.'* (GP 1, E)

*'It's a very difficult situation, the biggest risk of having something like that is missing the point, misinterpreting what somebody is saying because you have got to be careful of that you could get the wrong end of the stick altogether but you have got to understand that, whatever is being interpreted is being interpreted correctly. I would need to be assured that the interpreter has full knowledge of both languages so they can interpret word for word'.* (GP 5, SA)

Comments on the use of interpreters showed that GPs consultations were possibly compromised using an interpreter or advocate.

*'I know that I am not providing the same service that I would with somebody who I could converse with myself, it is more difficult, and you are almost sort of doing damage limitation and it is not as full a service as you would do otherwise.'* (GP 2, E)

*'For this practice that they would ask see one of our Asian partners who would normally be able to speak to them in their own language and that for some reason if they could not get in to see them and yet they would still come. The other thing that happens very often is that somebody comes in and can't speak very good English but their partner or their friend or their relative will come with them .....so we'll have a consultation with an' interpreter' but makes it more difficult.* (GP2, E)

*'Even if I speak that language there are still certain terms which I may not be knowing how do I expect an interpreter to know that, maybe he may not interpret the right term of the patients saying, there are a lot of mistakes and things to happen on the way.'* (GP 3, SA)

There was low awareness of the availability of telephone translation services. One 'white' GP used the telephone service for patients speaking European languages.

*'It is quite cumbersome and it works quite well for the asylum seekers from Kosovo or wherever and because they seem quite used to mechanics of it and they are not intimidated by the machinery of it but I must say I have not tried it with the Asian patients, I don't know how they would feel about it.'* (GP2, E)

Both GPs and community pharmacists (see next section) had limited knowledge about their patients' use of NHS Direct and they did not promote the use of these telephone help lines to their service users. Only one 'white' GP used telephone help lines for translation purposes. At the time of the study, there was no facility for NHS Direct to have interpreters, although interpreters can be requested by patients whose first language is not English. 'Language line' services have been locally set up in Leicester City (the Ujala Centre)<sup>15</sup> and the outcomes of this method of service provision need to be evaluated. The issue of using interpreters, translators and 'language lines, as well as 'NHS Direct' has also been further explored with South Asian participants, as the lack of knowledge of this method of communication by both GPs and community pharmacists could mean that a valuable resource may not be meaningfully utilized, despite recommendations for the provision of such resources highlighted in major reports (Johnson, 1999, 2001; Szczepura et al (2004, 2005) and Government policies (DH, 2004d)

### **Other communication methods**

One 'white' GP commented how prescriptions could be used as a form of communication because it was the only way to overcome communication barriers at the end of a consultation.

*'I think some of the time we are guilty of giving people a prescription because we assume that they want a prescription and I think some of the south Asian patients, if there is a language problem and you can't really explain it is easier to give them a prescription because then you feel that you have made them happy even if that wouldn't necessarily be what you would do with a Caucasian patient that you could explain things to.'* (GP 2, E)

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<sup>15</sup> <http://www.lcchs.nhs.uk/ Services-UjalaService.aspx> (accessed Dec 2009)

None of the GPs interviewed held clinics specifically for people in Asian languages. As four of the GPs interviewed spoke South Asian languages the issue was not raised but the other one European GPs had the following comments.

*'As a practice we probably haven't got a population to support it but if there was a locality-based thing it might well be an option.'* (GP 2, E)

One GP admitted using gestures to communicate simple dosage instructions. GPs welcomed the idea of pictograms to explain for example dosage instructions on medicines. Another personal example was cited on the use of different colours (e.g. of different tablets) to help compliance and make it simple for those who could not read or write the language.

*'Usually with gestures and most of the time they are very simple, you know like instructions of 3 times a day or every day that sort of thing* (GP2, E)

*'Lets say a person is given an anti hypertensive medication he is given an anti diabetic he has got four medications, then we have got four colours you tell them your pink is for hypertension you blue is for blood pressure this is for that they will remember that. The confusion is that they can't read or write and if all tablets or medicines are white or they change colour what is going to happen?'* (GP 3, SA)

For more complex issues, one GP shared the following suggestion, but also commented later that he does not routinely tell patients that pharmacists could clarify issues, but acknowledged that the pharmacist's role to intervene.

*If I have had to do something quite complex I would probably get the patient to come back several times to re-explain this, or adjust the dose. This is where I think the pharmacist could do the clarification'. (GP2, E)*

At the time of the interviews, the idea of a potential Medicines Use Review was being considered for inclusion into the New Pharmacy Contract as an advanced service, but none of the GPs had heard about this service.

One GP commented that not all pharmacists or doctors could speak all Asian languages and that other communication methods could be explored. Two European GPs actively suggested ways of improving the uptake of health promotion leaflets

*'We talked about a big leaflet rack but what tends to happen is that they tend to get tatty and people don't take them whereas I found*

*that targeting them and actually choosing the appropriate leaflet for people is more effective.’ (GP 2, E)*

*‘I have noticed that some of the leaflets we have out and certainly the posters we have out in different languages .....These seem to spark an interest....maybe that’s because it’s a relatively new introduction perhaps.....and people are beginning to think.... ‘They are actually beginning to use my language at last’ sort of thing. (GP1, E)*

Contractual obligations for community pharmacists and GPs do not require practice staff to actively encourage service users to pick up leaflets relating to health promotion or education. There is no requirement for community pharmacies or GP practices to evaluate whether or not leaflets are actively promoted or whether their impact has been useful. In Theme 5, other ‘educational’ methods have also been suggested which could be used for improving communication of important health promotion messages.



Theme 5: Education and Training
<b>Sub themes (and categories)</b> Population demographics Training for doctors and practice staff Education of patients

### Population demographics

Four of the GPs interviewed did not routinely enter the ethnic background of their patients on their computer systems. One GP entered background data that could be used for research purposes (such as data on CHD status, diabetes, obesity). All the GPs thought that the information would be useful to have. Emphasis was put on getting the information from everybody and that getting the relevant information would be more useful.

*'We have not at the moment got a system where we routinely get a history of the cultural background of these patients. But I think this is important to get it right in terms of this information. It would be helpful to have this information so that we can help to plan better things like health promotion activities'. (GP1, E)*

This is now a mandatory requirement within the quality outcomes framework within the new GP contract. The Government has recognised and endorsed the importance of the recording of ethnicity data and has produced a detailed policy guide on this subject (DH, 2005b). As of 2006, the new GP quality and outcomes framework (QOF)<sup>16</sup> includes the evaluation of the quality of recording of ethnic background for their practice population, which is a mandatory requirement. The findings of this study support the need for this requirement. However, no specific national targets have been set for evaluating health outcomes with respect to minority ethnic groups. It is also significant to note that despite this requirement for GP contracts, the capturing of ethnicity data is not mandatory for community pharmacists in the New Pharmacy Contractual Framework introduced in March 2005. Empirical studies (see Chapters 2 and 3) rely on epidemiological data retrospectively obtained through national surveys (Census data, General Household Surveys etc) conducted periodically, which may not necessarily reflect the changes in current policy, and results of such surveys may not be available at the time of conducting research. A limitation of this PhD study is that latest statistics reflecting the health of the local

<sup>16</sup> (<http://www.qof.ic.nhs.uk/> accessed October 2008).

population were not used due to lack of availability of local data from the Primary care providers.

### **Training for doctors and practice staff**

None of the GPs had any formal training on cultural issues. All the GPs interviewed welcomed the idea of training on relevant cultural issues for them and their staff. Examples cited were information on alternative medicines / practitioners. All the interviewees admitted that they relied on their personal knowledge and that those who had staff of South Asian origin had no relevant training on these issues and relied on their own knowledge or knowledge acquired by their personal experience.

*'Information for the medical profession, information for the nursing profession, the right type and standard material to be used throughout education leaflet, audio visual, whatever it should have been standardised every practice' (GP 3, SA)*

A contributory factor to the perceived lack of knowledge may be due to the lack of appropriate training around 'cultural' issues and health inequalities generally received by professionals in their undergraduate and professional education, and this has been discussed in the literature (Dogra, 2005; Culley and Dyson, 2001). The arguments put forward illustrate that GPs have a professional responsibility to provide high quality care that is sensitive to the patients' needs irrespective of patients' ethnicity or social class, and conclude that GP training should include issues surrounding ethnicity, race and racism and its relationship to health and health care. Studies by Dogra and her colleagues confirm the need for such training in undergraduate medical curricula (Dogra, 2005; Dogra et al 2005) and but some authors do caution against a 'check-list' style of 'training' and advocate a more 'responsive' model for training (Culley and Dyson, 2010). This was also explored with community pharmacists, and it was pertinent to explore from South Asians themselves as to how this population perceived such 'education' to be delivered.

### **Education of patients**

GPs described the education of the 'illiterate' as a 'dilemma'. Two GPs cited a multi-disciplinary approach and the use of community initiatives to be the best way.

*'We have been over the years expressing our views how to tackle the problems and one of them is really education of the community on a large and consulted way and on a continuous scale. This must be overcome by taking time to explain and overcome certain issues and it is with help of religious leaders and things that might be a way to overcome this. It requires effort and time.' (GP4, SA)*

*'Its not only on people who are not educated I come across younger generations, educated, born in this country they have still got the same beliefs'. (GP3, SA)*

*'Personal one to one education of a patient, I think it's more audio visual should be there maybe a group session, where it is a group they learn themselves you put in your idea, they put in their ideas, you have got to bargain your way in this class and facing that difficulty we are trying different methods' (GP3, SA)*

*Maybe like these group discussions, maybe neighbourhood centre conferences where there is an attraction that this is what we are doing. There is a free lunch we are doing assessments diabetes, blood pressure, skin conditions. I think it needs to be in a big group maybe something like a patient event, maybe in a clinic, a neighbourhood centre a community centre' (GP5, SA)*

All the GPs interviewed were generally positive about the use of media services for health promotion and education. The use of audio-visual aids (e.g. videos) was cautiously supported provided they were available in the appropriate languages, affordable and used in appropriate settings. All the GPs were positive about Project Dil (see Glossary).

### **Box 13. Key findings from GP interviews (Phase 1)**

- GPs views of the community pharmacist's role as a 'shopkeeper' or 'businessman' still prevalent, although the idea of a more 'health care professional' role was forthcoming and welcomed, particularly the concept of private consultation rooms.
- GPs commented that South Asians consulted more frequently for minor ailments primarily for 're-assurance'
- GPs felt that South Asians consulted for 'multiple' problems and were 'poorer' historians compared to 'white' patients and that South Asians did not readily discuss 'stigmatized' conditions (e.g. mental health problems).
- GPs noted that 'presenting' symptoms could be interpreted as 'minor' symptoms but could 'mask' an underlying psychological problem, and that unless adequate time was given during the consultation, these conditions could be missed.
- GPs commented that South Asians consulted less frequently for chronic conditions, many of which do not have overt somatic symptoms (e.g. hypertension).
- Those that did consult GPs frequently came for advice on minor ailments, and it was said that their expectation of a prescription was due to mainly financial constraints.
- GPs commented on factors that could lead to 'confusion' about medicines for example colour and shape changes could be difficult for them to explain to patients and that such interventions could be dealt with by the pharmacist.
- GPs did not routinely use patient information or health promotion leaflets (translated or otherwise) during consultations and commented that the impact of the information contained was questionable.
- GPs favoured more visual methods and suggested that educational means such as the media and community centred initiatives should be used more widely to encourage health education and promotion where 'concordant' health outcomes could be better achieved
- GPs were supportive about the need to be more aware of training and education about the cultural and traditional health care beliefs of their patient population, and that this was also important for their practice staff but needs to be consistent.

These findings are consistent with the findings in the literature and are discussed further in the chapter together with the findings of the interviews with community pharmacists.

An important finding that appears to be different to the literature is that despite the perception of the pharmacist as a 'shopkeeper' most GPs welcomed the 'changing' role of the pharmacist. Initiatives such as pharmacy 'triage' and minor ailments services were discussed in a positive manner but only once GPs understood the underlying concepts of such services and that such initiatives would be underpinned by appropriate governance processes, including consultations with medical and political stakeholders. The principal investigator had to explain what 'training' the pharmacist had undergone and what 'extra' training they would also need to do before 'advanced' and 'enhanced' services envisaged in the new Pharmacy Contract. Most GPs were unaware of what the community pharmacists' current undergraduate and professional training entailed. This was not reported as a theme in any of the literature monitored before the commencement of this research, although possibly underlying the publication in 2009 by National Pharmacy Association (BMA/NPA, 2009). The notion of improving 'professionalism' and 'professional status' of the community pharmacist was discussed and GPs were positive about promoting this aspect of the pharmacists' 'new' roles.

Issues such as the difficulties encountered with mental health consultations, contraception and 'stigmatised' conditions with South Asians appeared to be a novel interesting finding, at least within the pharmacy literature. The limitation of the findings from GPs is that 'saturation' was not reached in order to be able to make conclusive comments about this aspect. The emerging themes were explored with both community pharmacists and South Asian focus group participants to get a more holistic overview about many of these insights.

## **SECTION 5. 2 Phase 1: Findings from Community pharmacists' interviews**

### **Demographic data**

Data was collected before the interview to illustrate the demographics of the pharmacy practices, the profile of the participants and their practice staff and this is illustrated in Table 27 (page 232). This illustrates the demographics of the chosen pharmacy, and the status of the community pharmacist practicing in the pharmacies. Pharmacists were chosen from different backgrounds, including proprietors, managers and locum pharmacists. Four female (participants 1, 2, 3 and 4) and one male pharmacist (respondent 5) participated. Three participants (3, 4 and 5) were South Asian (Hindus) and participants 1 and 2 were 'white' (European). South Asian participants (3, 4 and 5) worked in independent pharmacies in the areas of Belgrave and Highfields and 'white' participants (1 and 2) worked in a larger City Centre multiple. All participants had been qualified for over 5 years and have practiced as community pharmacists for over 5 years. Participants 3, 4 and 5 spoke at least one South Asian language. All the pharmacy sites employed members of staff that was from a South Asian background and had at least one member of staff that spoke a South Asian language. Only one pharmacy had a 'private' consultation area where pharmacists could speak to patients of service users without being overheard. Health promotion leaflets were sporadically displayed in all pharmacies.

As illustrated in the previous chapter (methodology) the researcher has made a reflexive diary of her observations of the each community pharmacy setting. I did this as so as to have a better understanding of the different 'ethnographic' settings of the interviews and that this may give me a better understanding of potential variations in the pharmacists' responses to the questions. The reader is invited to refer to Appendix 5 for examples of such 'vignettes'.

Participants were also asked to indicate what percentages of their practice patient population were from a South Asian background. None of the participants had defined numbers, but all gave an estimated figure. This is illustrated in Table 26 (below).

**Table 26. Estimate of South Asians patients using pharmacies in which the participants were working (according to the participants)**

<b>Respondent</b>	<b>South Asian patient population using pharmacy (estimated by the respondent)</b>
1	30-40% (religion or cultures not known)
2	50% (religion or cultures not known)
3	80% in Leicester mainly Hindu, Moslem and Punjabi 20% in Loughborough (mainly from Bengal)
4	95% , mainly Hindu, Moslem and Punjabi
5	98% mainly Hindu, Moslem and Punjabi (20% from Sri Lanka)

**TABLE 27. Pharmacist practice demographics: questionnaire analysis**

Pharmacist no. (Male M Female F)	Pharmacy location	Nature of employ-ment*	Length of time in pharmacy practice	Background (and religion if from S Asian origin)	S Asian language spoken	No of counter staff from S Asian background (any who speak S Asian language)	Private consultation area	Display /promotion of translated information	Type of information displayed
1 (F)	LE1 (city centre)	M	11-15 yrs	European	None	7 (Yes)	N	N	Health promotion leaflets
2 (F)	LE1 (city centre)	M	11-15 yrs	European	None	8(Yes)	N	N	Health promotion leaflets
3 (F)	LE4 and LE12 (Highfields and Loughborough)	L	6-10yrs	Indian (Hindu)	Hindi, Punjabi, Gujarati, Urdu)	2(Yes)	N	N	Services and Health promotion leaflets
4 (F)	LE4 (Highfields)	P	>15 yrs	Indian (Hindu)	Hindi, Gujarati	4(Yes)	N	N	Services and Health promotion leaflets
5 (M)	LE2 (Belgrave)	P	>15 yrs	Indian (Hindu)	Hindi, Gujarati	2(Yes)	Y	N	Health promotion leaflets

\*M=employed by a multiple, L=locum, P=proprietor



The aims for the community pharmacist interviews were:

- to determine the personal views of local community pharmacists of their professional role in meeting the needs of the South Asian ethnic minority patients
- to explore the community pharmacists' awareness of any cultural beliefs of the South Asian ethnic minorities that could influence the use of medicines
- to identify incentives and barriers community pharmacists perceive which could influence the use of their services

Twenty two 'categories' or 'aspects' emerged from the data. These are defined in Table 28. These categories were grouped to form five distinct themes, illustrated in Table 29.

**Table 28. Categories from the Pharmacists interviews**

Category or Aspect	Category label (or description)
1	Knowledge of demographics
2	Computer information
3	Opinions of the South Asian population needs
4	Training on ethnicity, cultural beliefs and attitudes
5	Health promotion (education)
6	Use of interpreters and translators
7	Extended roles
8	Barriers to pharmacists/pharmacist services
9	Access to pharmacies/pharmacist services
10	Access to health services (other than pharmacy)
11	Promotion of pharmacists role
12	Current perceptions of pharmacy services
13	Health promotion (communication)
14	Patient Counselling
15	Health seeking behaviour
16	Religious and dietary beliefs
17	Use of alternative and complementary medicines/practitioners
18	Government initiatives
19	Fate (karma, belief in God curing all)
20	'Hot and cold' beliefs
21	Extended family influences
22	Other communication methods

**Table 29. Main themes from Pharmacist Interviews**

<p><b>Theme 1. Perceptions of pharmacists and services</b></p> <p>Categories: 7, 8, 9, 10, 11, 12, 18</p>
<p><b>Theme 2: Consultation patterns</b></p> <p>Categories 3, 15,</p>
<p><b>Theme 3: Cultural issues</b></p> <p>Categories: 16, 17, 19, 20, 21</p>
<p><b>Theme 4. Communication</b></p> <p>Categories 6, 14</p>
<p><b>Theme 5: Education, information and health promotion</b></p> <p>Categories: 1, 2,4, 5, 13, 22</p>

The findings are presented under these themes and the associated categories, supported by verbatim quotes and the researcher's reflexive diary entries to substantiate and illustrate the meaning of the data.

Pharmacists' names have been anonymised and their quotes have been tagged with individual respondent numbers and ethnic backgrounds, which allows the reader to refer to Table 27 (page 232) for further reference to their background.

Example: 'Quote' (Pharmacist Respondent no, E='white' or European, SA-South Asian, I-independent contractor, M-employee of a multiple chain, L-locum pharmacist)

Theme 1. Perceptions of pharmacists and services
<p><b>Sub themes (and categories)</b></p> <p>Current perceptions of pharmacy services</p> <ul style="list-style-type: none"> <li>Perceptions of their own roles</li> <li>Professional recognition</li> <li>The shopkeeper image</li> </ul> <p>Access to pharmacies/pharmacist services</p> <ul style="list-style-type: none"> <li>Pharmacists as the first port of call</li> </ul> <p>Barriers to pharmacists/pharmacist services</p> <ul style="list-style-type: none"> <li>The expectation of a prescription</li> <li>Cost of medication</li> <li>Remuneration and time for provision of new services</li> <li>Psychological influences: re-assurance and trust</li> <li>Access to medical records</li> </ul> <p>Promotion of pharmacists role</p> <p>Extended roles and government initiatives (including minor ailment schemes)</p> <ul style="list-style-type: none"> <li>Minor ailment schemes</li> <li>Screening and monitoring</li> <li>Private consultation areas</li> </ul> <p>Access to health services (other than pharmacy)</p> <ul style="list-style-type: none"> <li>GP receptionists</li> <li>Access for new migrants</li> </ul>

### Current perceptions of pharmacy services

All participants were invited to comment on how they perceived their own roles and how their services could be viewed by GPs and patients. Most community pharmacists confirmed that they were viewed as a 'dispenser' and that this was due to a 'lack' on their own role to promote themselves other than that. Barriers in promoting themselves were cited, and this included lack of time to do any 'self' promotion and that the location of the pharmacy could also be important aspect in how community pharmacy services were perceived.

*'Sometimes I think it is a perception of our role which is the problem rather than whether they go to the GP or whether they go to the pharmacist. I think the GP is seen as the font of all knowledge if you like and the pharmacist is seen as the person who dispenses the medicines, I think sometimes that is a problem.'* (P1, E, M)

*Pharmacists are notoriously bad in promoting their own role so in a way it is a problem all round because the whole thing is perpetuated and I think that is*

*particularly a problem in a pharmacy like a city centre pharmacy in a big multiple because the pharmacist has less time to talk to the customers than perhaps a little pharmacy so I think that is partly to do with the type of pharmacy that I work in as well.*(P2, E,M)

All the participants commented that most GPs were not aware of the current role of the pharmacist apart from the supply of medicines and that their role was not promoted adequately, especially by GPs

*I don't think they (GPs) are fully aware of what we are able to do. (P2, E, M)*

*'We are still not perceived (by GPs) to be complete professionals in our field.'*  
(P3, SA, L)

One respondent said that this population may undervalue the pharmacist's role because of their lack of knowledge of the pharmacist's ability to advise them of their condition or appropriate medication. There was discontent amongst all the pharmacists interviewed as to how they were perceived by GPs and the lack of communication and professional behaviour between the two professions. It is interesting to note that many of these issues confirm the comments from GPs and these are also explored further with South Asian focus group participants.

*I don't know really but people who do that sometimes it's because they feel as though the doctor knows best (P3, SA, L)*

*When you have recommended a treatment, the GPs do not accept that. Some patients actually are quite scared to tell the GP that they have been to see the pharmacist, especially when they say to the patient in a rather rude manner not to trust what the pharmacist sells them. Talking to many of the patients they are not satisfied with what the GP sometimes tells them (P5, SA, I)*

All participants said that professional communication between the pharmacist and the local GPs needs to be improved.

*'It's a major barrier between the GPs here and our population in this area and the communication from the GP to pharmacist. The patients sometimes appear confused.'* (P5, SA, I)

There was the perception that they were thought of as 'shopkeepers' by both GPs and patients of 'making a profit' on what they can sell. This was considered to be the case for all the pharmacists interviewed, and confirms the findings of the GP interviews on this category.

*'I think the doctors do not do enough to persuade people to come to us because we are perceived to be making profits on whatever we sell (P3, SA, L).*

*There is a gap in knowledge of what a pharmacist does amongst the Asian community here. The suspicion is with the pharmacist, he's going to try and sell me something that they do not want. They have this feeling that we are in it for a profit, just like an ordinary shopkeeper. (P5, SA, I).*

*For certain things they (patients) don't have a choice but to pay. They think we are making a profit so we are shopkeepers. (P4, SA, I)*

Two south Asian pharmacists identified that sometimes South Asians did come in confused about medication, particularly those that did not speak English. They also alluded that South Asians relied heavily on the GP for advice on changes to their medication. One respondent suggested a way whereby this could be overcome.

*I think doctors could confidentially say to people just go to the pharmacy and they will sort you out for those sorts of things and also in terms of giving advice on their prescription medicines as well. (P2, E, M)*

### **Access to pharmacies/pharmacist services**

The pharmacists' role was better perceived in the younger, more educated members of the population. One pharmacist did comment that there were differences in populations as to whether they used the pharmacist as a first port of call, and that this depended on the attitude of GPs in the area.

*'In the suburbs, the younger generation are coming to us (the pharmacist) as a first port of call (P3, SA, L)*

*I think some parts of the younger population I am sure are very well aware of our training as much as the white population are aware, possibly older generations aren't and they would be more likely to go to their GP as first line, I think that is more likely with the younger generation then it is not so much of an issue (P4, SA, I)*

*The major problem here is that GPs here in the City do not think the same as those in Loughborough (market town 15 miles north of the city centre). As the same pharmacist, you could go from here to Loughborough and get twice the patients there where GPs want to accept the pharmacists' role. There the patient comes back and says the GP said to go to the pharmacist first-that's really good (P3, SA, L)*

Some participants commented that many working patients who usually pay for prescriptions do tend to consult the pharmacist for OTC (over-the-counter) medication first because of lack of time to see the GP or the barrier of an appointment system.

*Most of the people in this area (predominantly South Asian population) come to us only if they can't get an appointment or can't get to see the doctor (P3, SA, L).*

Pharmacists were asked if 'triage or extended services' could be better accepted if they were located within the GP's surgery. There was a difference of opinion between city centre (Pharmacists 1 and 2) and suburban pharmacists (pharmacists 3, 4 and 5). The expectation of a prescription would still be important, and the possibility that the 'free' extended services could be abused.

*Actually located in the surgery yes I think that would be fine (P1, E, M)*

*I think they would still expect a prescription from the doctors and get it dispensed at the pharmacy whether it was in the health centre, under the same roof, they would expect a prescription. Personally if they knew they would be able to get their medicines from a pharmacist just like as if it were on a doctor's prescription they would abuse the service. (P4, SA, I)*

### **Opinions of extended roles and government initiatives (including minor ailment schemes)**

All participants were aware of the NHS plans cited in White Paper *Pharmacy in the Future* (DH, 2000b). They commented on their views for the provision of extended services such as minor ailments schemes and other initiatives, but they were cautious to comment how these roles would be perceived. There is overlap in these comments with the category of 'professional recognition' of pharmacist's role. Most community pharmacists discussed barriers to such schemes when interviewed, and these comments warranted a separate category (under 'barriers' further in this section.)

*Whether GPs will accept the concept of pharmacy 'triage' for minor ailments or enhanced services is a major barrier really. It would definitely work. Providing the pharmacists are accepted by the GPs or the local GPs are also informed (of pharmacist's role and that services are being provided) that it's alright for pharmacists to do this. It (National policy) also has to be accepted at a local level, not just nationally. (P5, SA, I)*

Two pharmacists commented that services such as pregnancy tests, blood pressure and glucose monitoring are frequently sought after by South Asian service users. It is suggested

that the pharmacist's role be promoted positively similar to that of a nurse within the practice (i.e. time saving) for services such as blood pressure and glucose monitoring. However, participants also discussed the need for recognition of such service provision by other health care professionals.

*We are getting a lot more requests about things like blood pressure monitors and glucose meters and I would say that a large number of those requests are from this particular group (South Asian groups). I think a lot of Asian people would find that helpful and blood pressure monitoring because these seem to be the things which come up again and again. I think it would be helpful if that sort of thing was available without them having to purchase their own machinery and do it at home, yes, I think that would probably be a plus. (P1, E, M)*

*I think screening and extended services could work if all parties were willing. I don't know whether they would be. I think if there was somewhere some proper referral system in place so seeing a patient and referring them I think it would be fine. (P1, E, M).*

Three pharmacists did mention that they would prefer adequate training and development for these initiatives and that proper systems would need to be in place for these services to work. In addition, this would promote the trust of the GPs in the services.

*People of this population like their blood pressure being measured. If this was offered, we would be quite busy but how useful this would be is difficult to say. They may be panicked. I personally feel that they should be explained about the importance of checking and that they may have to come back. But if they panic and get on call doctors out it would not be a good idea. It's the same for glucose testing and all that-many times patients panic (P3, SA).*

*They (extended and new services) would need to be carefully promoted (P1, E, M)*

*I do not feel comfortable with providing a (screening or extended) service without the doctor's support (P4, SA, I).*

*Doctors who are not informed or not confident about the pharmacist ability may not happy and tell the patient 'the nurse will do that (monitoring)'. (P4. SA, I).*

All the participants commented that the idea of a private consultation area for the provision of extended services was a good idea. One independent pharmacy had an area which was considered to be private' or 'quieter' areas where patients could sit down and be in a more relaxed frame of mind, but were not classed as a private consultation area. All participants



commented that having such areas would be beneficial to all populations and encourage not only frequent, but a more 'professional' contact.

*I think it would change the whole dynamics of the pharmacy (P1, E, M).*

### **Barriers to the use of community pharmacy and extended services**

Participants observed that South Asian patients went to GPs as the first port of call in the expectation of a prescription. Many reasons included the notion of the cost of medication, but also discussed other influences. Most participants commented that the perception of obtaining medication on a prescription which they did not have to pay for was one of the main barriers to consulting the pharmacist. This was not considered to be unique to South Asian patients.

*Well there are a number of patients who do go to the doctor with the expressed intention of coming away with a prescription. (P2, E, M)*

*I think it (the expectation of a prescription) is possibly an issue for some yes, again that is difficult because you don't have any evidence of that but certainly sometimes you will get 'I can get that free from my doctor' even with children's medicines like Calpol<sup>(R)</sup> (P1, E, M).*

*The people who do not pay go to the doctors first. In my area, they come to me as a last resort. The ones that pay for medicines come to me first because they do not have time to go to the doctors because they are working. In our area, even the young patients happen to be on (government) benefits so they go to the doctors first. They have the time to sit at the doctors for a free prescription (P4, SA, I).*

*The population here would rather go and sit hours and hours in the surgery and get 30 paracetamol instead of coming and spend that 50 or 45p on them. It's just the way it is with people in our area (**probed to clarify**)..... 'Our Asians – they don't want to understand. They think it's their 'right' to get free prescriptions so why should they pay for it? (P3, SA, I).*

*When they come down to the pharmacist they have a feeling that 'ah wait a minute we have to pay there' so that is the biggest barrier (to the pharmacist as a first port of call). (P5, SA, I)*

*If they want 50 paracetamol tablets (from the pharmacist) it is still £xxx. With GP they go they have 50 paracetamol and it's free on prescription. The majority here (of local population) don't pay. **Probed....why?** Because lots are on income support (P5, SA, I)*

Participants were asked their opinions if the removal of the 'cost' barrier would improve perceptions

*It (removal of cost barrier) would alleviate quite a lot of problems because then we all think the pharmacist is the first line of healthcare. However, with 70% of people of the population in our area in Leicester (predominant South Asian community), there are not many who say to themselves that 'by going to the GP they are going to waste two hours / three hours' .....for a painkiller or probably something for cold and cough. They would rather wait (for a prescription) than come and ask the pharmacy and buy this stuff (P3, SA, L) **Probed.....why?** 'I think they have already made up their mind they want a specific product (like Calpol), but because children are entitled to it free, they do not want to pay. **Probed..... do they ask you for advice?** Some of them do, but even then they go back to the GP. They like the advice, but still prefer the GP. (P3, SA, L) **Probed why is that?** It's always been the case with Asian people. We are only here to provide their medication, that's what they think (P3, SA, L)*

One respondent discusses that there is a 'change' in some of the GPs prescribing patterns, and this was noticed by one of the 'white' pharmacists in the City Centre.

*I think the cost thing sometimes is an issue, but the perception that the GP does will give them something (on prescription) for nothing (a minor complaint) is another issue. GP's are tending not to prescribe some of these things (medicines that can be bought over the counter for minor ailments) so often any more anyway.  
(P1, E, M)*

Participants also suggested that appropriate remuneration and incentives needed to be clear for new government schemes to work. Time was also considered to be important and the concept of 'sole pharmacist' mechanics had to be revised

*At the end of the day it all depends on how they (the higher authorities) are going to remunerate you. If they are going to remunerate you can always make facilities, if you haven't got it you can make them available. But if there are going to be no payments for it you are not going to do it as simple as that.  
(P4, SA, I)*

*'It seems all like a good idea but I really find there isn't currently the time available, much as we would like to do it. (P1, E, M)*

*Financial barriers, there are always going to be financial barriers. One's needs are never satisfied. As long as there is some sort of incentive some sort of payment then it should work. (P5, SA, I)*

One respondent commented on contractual arrangements in addition to 'spatial' reconfiguration of pharmacy premises as a major concern

*I think on the whole (medicines management and enhanced services) would work although I am not sure it is all going to happen perhaps as the government thinks it will, because- well the way pharmacists are paid, the way*

*the pharmacy premises are organized it doesn't automatically lend itself to these sort of enhanced services (P2, E, M)*

Financial implications for reconfiguration of community pharmacy services and further changes in contractual agreements could add more 'stress' to the current pharmacy service configurations. The White Papers have also indicated that there are 'reconfigurations' in the global budgets set for pharmacy, but it is evident from the findings of this study that pharmacists were cautious about commenting on this. Pharmacists commented on 'complex' barriers that could influence South Asians to go to GPs first. These include the need for South Asians to be re-assured by pharmacists and build trust in their services, in addition to the recognition of their professional status by GPs (illustrated previously).

*They undervalue advice which they could get from pharmacists possibly or they are expecting to get a different product on prescription to perhaps one that they could buy. Also, they may want somebody to tell them what's actually wrong with them rather than the person who knows what is wrong with them and then just wants to sell them a remedy for it. (P2, E, M)*

*I think the message they (GPs) give to their patients is that they get better, more expensive things on the prescription.' (P3, SA, L)*

*'Obviously you would have to have the confidence of the patients first because otherwise they are not going to have trust what you are saying anyway and I think that is something again that needs to be built over time and needs patience. (P1, E, M)*

*It has taken them to get to know me for a number of years, and many people now consult me for minor conditions. I find now some of them do come to me first, particularly Hindus, they come first to the pharmacist. Because they have the trust...**probed-so isn't cost an issue (as you said before)?** 'No, because they (South Asians) know I have time and understand their reasons for needing re-assurance about their symptoms and you need to get down to 'their level' –**probed-what do you mean by that?** I get them to open up a little more by empathising with their discomfort. I speak Gujarati, so it makes a difference. I understand the dialect and how they express themselves. (P5, SA, Hindu)*

These themes were also discussed in detail with the focus group participants in the second Phase of this study. It is interesting to see similar perceptions as for GP interviews in that 're-assurance' was perceived to be a factor in a consultation.

Most pharmacists did not have any access to the patients' clinical record and this was cited to be a major barrier to providing advanced and enhanced services, particularly medicines use

reviews and 'triage' services such as minor ailments schemes. The respondent also commented that patients not being 'registered' with one pharmacy could cause further confusion.

*You don't know what medication they are on, patient history you don't have their background. (P4, SA, I)*

*You cannot do it (provide enhanced services) if they have taken one prescription here and one prescription for another drug somewhere else. You actually have to have them registered at one pharmacy and that patient only goes to that pharmacy, then it is effective otherwise it is not effective. If they take one prescription here and one somewhere else we (pharmacists) have no idea what is on their Patient Medication Record (which is held in a pharmacy). (P4, SA, I).*

### **Promotion of pharmacists' role**

Participants commented that educating the patient on the pharmacists training would play an important part if the pharmacist was accepted as a health care professional.

*Obviously if our role was promoted then they would be more aware of what was available to do and what sort of knowledge base we had and so any promotion from any health care professional who they had to come into contact with would be useful. (P1, E)*

*If we had a day when we could get together with the mums and in a 'discussion' event, at least they knew that the information they are getting is first class and not from the newspaper. They would believe us more I think. (P3, SA: reflexive diary entry)*

The idea of the community pharmacist becoming more 'responsive' in a community setting and involving 'community' based decisions and events was an area that was further explored with South Asian participants. All pharmacists commented that their role is not promoted adequately or professionally by health care professionals.

*Pharmacists are notoriously bad in promoting their own role as a health care professional first. It's difficult when we also have business pressures and business targets to meet. It is more 'obvious' that we are business people (P2, SA, I)*

*The role of the pharmacist is understood by the learned people, it's promoted amongst the educated people who understand this. It's not promoted amongst those people we are talking about in the middle of Leicester and that is where the big gap is. **Probed...what do you mean?** 'Within the Asian population-in our area (Belgrave) most of our population comes from India or East Africa-*

*they are still of the mindset that we are businessmen first, and then a health care professional. Here in UK it is different-we have a different role to that in Africa-but we can't change people's mindset. The people in this area are not educated to understand that. (P5, SA, I)*

*I very much doubt if GPs promote the role of the pharmacist. I think it is very unlikely. (P1, E, M)*

All participants commented that GPs had to be a willing party if any new initiatives were to be promoted. GPs needed to 'change' the way they referred the patients to pharmacists and not to 'undervalue' the role of the pharmacist and their training. This would be particularly important for new initiatives and extended services.

*Whether GPs will accept the concept of pharmacy triage or enhanced services is a major barrier really. Some GPs feel that their role could be diminished by the pharmacist (P5, SA, I).*

The notion of a 'consumerism' based 'business' approach and image can also affect the 'professional' image of the community pharmacist. These concepts have also been explored in the wider literature in the white population (Bell et al, 2000; Hibbert et al 2002). The findings of Phase 2 of this study (Chapter 6) also show that South Asians relied on a significant input from not just a healthcare 'professionals' for the education and management of their health, but also family members and extended community networks.

### **Access to other health services**

During the interviews, pharmacists commented on barriers to GP services and access issues. Three participants commented that access to health services by some South Asian service users, particularly GP services, were hindered by appointments systems and the attitude of the GP staff, and felt frustrated by the bureaucracy and the lack of professionalism.

*To book an appointment a week before or a week after you are ill that is ridiculous. There are surgeries where they (receptionists) say 'I can't give you an appointment until next week'..... that patient can die (P3, SA, L)*

One pharmacist also commented that GP receptionists were particularly unhelpful in advising them about how patients can register with practices, particularly those who have recently migrated to the UK.

*It is very close community and they try and help each other out and registration in that area is very difficult and people used to come to us and obviously we*

*couldn't do much, just keep the names. Their leaders used to come and ask whether we could do anything to help them (medically). When we rang the surgeries they (GP receptionists) were rude to us. (P3, SA, L).*

Many of the comments and categories illustrated in this theme correlate well with the categories in the GP interviews in the previous section. Many of these comments were also explored with South Asian service users in the next phase of this project.

Theme 2. Consultation patterns
<p><b>Sub themes (and categories)</b></p> <p>Opinions of the South Asian population health needs</p> <p>Health and Lifestyle issues</p> <p>Travel health</p> <p>Health seeking behaviour patterns</p> <p>Male/female consultations</p> <p>Stigmatised conditions</p>

### Opinions of the South Asian population health needs

All participants were invited to comment about the health and health seeking patterns and behaviour of the South Asian population in the areas where they predominantly worked. All participants discussed their awareness of the higher prevalence of major disease areas (e.g. hypertension, coronary heart disease and diabetes) in the South Asian population. Differences between the health of South Asians and Europeans were shown by one respondent. Pharmacists alluded to various areas of health and lifestyles pertinent to this population, including a higher prevalence of cardiovascular disease, weight management issues, diet, diabetes and exercise.

*I don't think the (health) problems are the same for South Asians and Europeans. I wouldn't say as a group they (South Asians) are any healthier or less healthy, obviously each group has a certain spread of disease I think there are certain things which are more of a problem. (P1, E, M)*

*Weight issues and diet issues are certainly more of an issue (in South Asians). Diabetes is probably more prevalent in the South Asians, but largely as a knock on effect from the diet (P2, E, M).*

All pharmacists commented that a significant percentage of their South Asian service users travelled abroad.

*We are asked (about travel medicine) those who have not travelled for a long time or are on medication things like insulin, they do ask for advice (about insulin). (P3, SA, L).*

*There are a lot of people who go back to visit India and Pakistan and various places and malaria protection is going to be helpful for that population. There are a lot of people going on holiday, but we certainly get a lot of requests for malaria. (P2, E, M)*

*I think now you find that people travel more than they have ever done, even elderly and youngsters they travel more than they have ever done. (P4, SA, I)*

Two South Asian pharmacists commented that travel medicines were not used because of costs, and that conflicting advice between GPs and community pharmacists added to the complex reasons underlying patients' perceptions.

*Some (South Asian) people go to India or exotic tropical holiday. They come to me when they been they have told by the GP to go and see their pharmacist for malaria tablets-then they come down here. It is not the fault of the pharmacist that the tablets are £15.50 for a pack at all. They can't sell it cheap because its price maintained. When you tell them that's £15.50 and four people are going on holidays obviously you can see what the response they are going to get.....some patients walk out in disgust. They just don't want to buy it; they think going to pharmacist is going to cost us money. By the time you show them the (cost of) malaria tablets, you show them diarrhoea tablets and anti mosquito bites preparations you show them this and they just get put off. (P5, SA, I)*

*Everybody knows they have to go for vaccination and they will go for vaccinations. When they go for vaccinations I think the nurses actually make sure they know that they have to take all these medications which are not now available on the NHS, like malaria tablets and things like that so I think they drum that into them anyway, but they do not take the tablets because they do not come to buy them. They ask for the cheapest alternatives and then they come back with malaria or whatever it is more work for the doctors. I know that some patients think they are immune to it (P4, SA)*

These issues are linked with 'openness' between the pharmacists, GPs and nurses. They revealed that even though anti-malarials are recommended, there is no mechanism to check for concordance.

*If the doctor or nurse advises people about malaria tablets say for example, the doctor or nurse should inform us that they are recommending this and that they are sending the patient to come and see us. We should then be able to ring back and confirm that the patient has been to see us. Then the doctor can be aware whether the advice has been taken up. At the moment I would not do that because the doctor has not informed me and patient confidentiality does not allow me to tell the doctor. This can cause mistrust. But if it was all official and the patient knew that, I am sure they would take the malaria tablets. (P4, SA)*

The 'confusion' in patients' perception of the importance of travel medicine (including malaria prophylaxis) and the cost of such interventions was confounded by the lack of effective, unified messages from other health care professionals, a finding which adds validity to the findings from Jesson et al (1994b), who showed that most of this advice was given by the GP.



Mixed responses were obtained from the participants about consultations for minor ailments. The South Asian participants said that a high proportion of South Asians did come to pharmacists with prescriptions for medication for minor ailments. Patients went to the GP for most prescriptions for minor ailments due to socio-economic factors and these perceptions have been illustrated in the previous section. However, one 'white' respondent did compare consultation patterns between European and South Asian patients.

*They (South Asians) consult less I would say than the general population, on the minor ailments possibly because they self treat with traditional remedies although I don't know that this is the case or possibly because they don't particularly believe in treating things like minor ailments. (P1, E)*

### **Health seeking behaviour patterns**

There was no evidence to suggest that there were differences between patterns of male and female consultations. However two female South Asian pharmacists commented that the fact they were female and Asian could influence these consultation patterns, especially amongst specific populations e.g. the less educated or illiterate. However, this was not thought to be unique to the South Asian ethnic minorities. The gender of the pharmacists was important when consulting for 'sensitive' issues (e.g. women's or men's health problems).

*I used to get comments that in this area (sensitive topics) that if there are female pharmacists and we would like to come and talk to me instead of going to the doctors. (P3, SA: female).*

*You find they come to you more for women's problems because you see them especially ladies you know because the Muslim women know there are no men working here. (P4, SA female)*

*Female patients do not come and see me readily with their problems. They would prefer a female pharmacist, or at the very least an Asian female member of staff. (P5, SA male).*

*Things like urine infections in males for example, that's one of the major ones, and they (men) don't know whether to tell us (female pharmacists) or not. Obviously when they do they are very shy or self conscious but I try and overcome it especially if they are male then men try and talk to a man, if they don't see one then they try and talk and I try and act normal, and explain everything as much as I can. (P3, SA female).*

All participants commented that stigmatised conditions such as depression were not discussed readily by members of this population, particularly in the pharmacy setting. Most South Asian participants suggested that this was because members of this population did not divulge such problems readily. . Not knowing the language was one of the barriers cited that could also hinder patients talking to pharmacists about stigmatised conditions. Participants also commented that patients used the pharmacy as an 'outlet' to discuss various social problems if the pharmacist was personally known to them. It appeared that younger people were more open about social problems and that the older generation who lived in 'joint family' situations found it difficult to talk about certain sensitive and stigmatised conditions.

*I doubt it unless they knew us personally .... (probed.....why?) Because they think that by telling somebody about it they might be considered weak and they don't have the willpower to work on their problem. I know people who used to come and talk to me about their problems and things only when they knew me..... otherwise they wouldn't just come straight to me. For me being a locum now it is very difficult, if I was based at one place I think they would come and talk. I find that (South Asian) people do get concerned if something is different than normal in their life and sometimes talking (to somebody they know) helps. (P3, SA)*

*I think in general I think South Asians don't like to admit that they have got depression. I find that Indians don't want to admit that they are depressed you know it is always like a taboo to them. You find that now the youngsters don't have that approach they will openly tell you that they are upset; they are stressed, if you actually ask them what has triggered it off and they will always be a reason for it. They are aware of it but you will find that the older generation will not admit it very quickly. You find however, a difference in with joint family situations..... (Probed..... why?) many patients discuss this in a joint family gathering, and many find that confidentiality is an issue and that their other community members will get to know and this could pose other problems . (P4, SA from reflexive diary comments noted after interview)*

*It (depression) is always going to be a problem, because (a) those people who come here socially left a life there to start a new life here they have got no social background here and they probably feel they are not accepted here and (b) they probably feel that now depression is setting in. They do not think they are depressed and find it difficult to accept. We only get to know when they are straight away put on 'Prozac'. Well up to now they didn't need it wonder why it is an issue. So they are not talking about it they are bottling themselves up. That area should be made aware of their life; they have to change their habits here. But people here still think it is a bad thing and taboo to be depressed as they are not accepted in society if they speak about it. They should be able to speak to pharmacists about this. (P5, SA)*

*'We had recently a problem among the younger female Ceylonese patients wanting advice on sensitive issues such as contraception. Many 'male'*

*patients came to the UK as refugees, now they are getting their partners here. When their female partners come here they have personal problems which they don't want to talk to anybody about. They seek advice and are 'afraid' to talk. They should be more aware that somewhere along the line they can talk to pharmacists and they are quite capable of seeing or talking them personally or privately and giving them some medication' (P5, SA)*

An interesting comment was made by respondent 2 of her perception of being a 'white' pharmacist dealing with what she deemed to be a 'cultural' issue' when discussing stigmatised conditions such as depression.

*Yes there is a difference there, there are some things I would be surprised to speak to that (South Asian) population, I would be surprised if they requested information about that directly from me, whereas for a 'white' person, it wouldn't be such a great problem so yes I think that is probably a cultural issue (P2, E)*

Theme 3. Cultural influences
<p><b>Sub themes (and categories)</b></p> <p>Religious and dietary beliefs</p> <ul style="list-style-type: none"> <li>Fasting</li> <li>Gelatin/alcohol content of medication</li> <li>Lead, kohl, betel nut</li> </ul> <p>Use of complementary therapies and alternative practitioners</p> <p>Hot and cold beliefs</p> <p>Extended family influences and generation differences</p> <p>Fate (karma, belief in God curing all)</p>

### Religious and Dietary beliefs

Fasting and dietary habits were cited by all the participants as a specific cultural issue in Hindus and Moslems.

In Hindus this was perceived to be more 'specific' religious belief and did not necessarily relate to total abstinence of food and medicine. The fast of Ramadan in Moslems resulted in revising routines for taking medication during the hours of daylight, which could cause problems.

*Ramadan and things like when they are fasting for Muslims, when they have to take their medication four times a day. In the beginning when I was working in Highfields, I couldn't really explain to them the importance (of compliance), but because they have to fast a whole month, they can't even break it. We used to like overcome it by telling them to take it in the evening time so its revise it, instead of taking it in the daytime then consider the day time as their night time. That does cause a problem. (P3, SA)*

*Many people cannot have tablets or they won't have tablets on certain days, their religious beliefs, they've got all different individual beliefs. For instance Hindus will not have tablets starting on a Monday they have got to start it from a particular day say Thursday or something like that. They don't have those tablets for three days. (P5, SA)*

*I have had conversations about when they should take their medications and adjusting their dose times (at Ramadan) in a sensible fashion so that they don't cause themselves any difficulty. Usually it can, with most medications, it is possible to get around it because of the timing of the fasting it is usually possible to get round it from the people I have spoken to, haven't perceived it to be a problem. (P1, SA)*

One European respondent said that she relied on her own knowledge on cultural issues about dietary habits underlying major long term conditions such as diabetes.

***Excerpt from interview with Respondent 1 and 2 ('white') on their understanding of the impact of diet and religion on compliance***

*As far as religion goes I don't know that this is a particular indicator to disease - I think cultural issues maybe are such as diet and I know certainly there are diet issues and I think high cholesterol is a problem for this population, probably due a great deal to the diet, so that is more cultural than religious I would have thought. As far as religion goes I wouldn't have said so but cultural yes there are issues and diabetes is one of them. I don't know enough about it really to comment but the way I understand it is the fasting usually occurs during daylight hours so normal eating goes on, so there is, so it is not as though they are not eating at all and they are allowed to certain things during the day I believe, I don't know much about that, they certainly are allowed to eat and drink some things during the day, but yes it could be a problem if they really weren't getting any sort of sugar or carbohydrates in during the day yes it could have implications for health, but it could have implications for health if they have other underlying disease states but I imagine, although I don't know, that there are waivers for people who are unwell, in any religion I would have thought.(P1,E*

*I have had conversations with people before, and they have said can I have a course of antibiotics but I can't take it at such and such time in the day, or they can't take it in between these times because I am fasting, and of course because I don't have any understanding of the individual religions and traditions then I don't really understand and it would nice if I did.(P2.E)*

Pharmacy participants also alluded to other religious beliefs that could affect concordance issues (for example the use of gelatin and alcohol in medicinal products). All participants cited this as a cultural issue, particularly in the Moslem patients.

*In dietary terms you get vegetarians in every group of the population but you certainly get vegetarians in the South Asian community and for that reason they may be reluctant to take things that have got gelatine capsules in them or have anything to do with an animal product, but I am not really aware of anything else. (P2, SA)*

*Because of halal, they keep on pestering you because of their gelatine capsules whether they have got animal fat, alcohol and so we do get all these sort of things. (P3, SA)*

*They will not have pills that have gelatine. We explain it to them and if they insist on not having them open the capsule up and put it in a spoon and drink*

*it. But they must know what is in it. Especially if for example the person is suffering from TB. Many will not take particular antibiotic capsules. They get suspicious about liquids and we spend a lot of time counselling them on these specific issues. (P5, SA)*

Two European participants had no specific knowledge in this area. Knowledge of such cultural issues could be of benefit for pharmacists and their staff as it could engage them to have more meaningful dialogue in relation to understanding medicines adherence.

The three South Asian participants cited examples of problems surrounding the use of betel nut, the chewing of tobacco (in paan) causing mouth cancer, particularly in Bengali women.

*I think a lot of patients are actually aware that betel nut actually causes it, whether they take any heed of it is another thing but I think a lot of patients do not actually know of things like that do affect them.’ (P4, SA)*

The opportunity for health promotion and education opportunity was not probed for from this participant, but was further explored in the interviews with South Asian participants. There is opportunity for the pharmacist to be more involved in health promotion and education for this population, and further examples are discussed in the Theme 5.

### **Use of Complementary or alternative medicines/ ‘home-made’ remedies and alternative practitioners**

None of the pharmacists proactively asked patients about the use of alternative/complementary medicines and alternative practitioners. The European participants commented that they had not observed any differences between the use of complementary remedies between South Asians patients and the ‘white’ population. All participants said that they did not have enough knowledge of differences between ‘alternative’ and ‘complementary’ medicines and were dubious about their clinical benefits. There were uncertainties about the use of ‘home-made remedies’. Concerns raised by some participants were the source and quality of ayurvedic and homeopathic medicines and their licensed indications. Information about the use of these remedies is volunteered if actively probed from patients. Generally, the participants did not know of sources to look up information on such products.

*Yes, a small percentage does use these (complementary) medicines mainly homeopathic and ayurvedic but there is not a big proportion who goes that way. From my experience the ones who actually go there are the ones who have tried everything else, doctors prescriptions haven’t worked and they find them going as a last resort. (P4, SA)*

*They use these more than the white population (P5, SA).*

All pharmacists interviewed were aware of 'alternative practitioners' although the two White participants were not certain of the use of alternative 'Asian' practitioners such as hakims and vahids. The Asian participants gave more insight to the use of these practitioners by members of their population groups and believed that such practitioners were consulted abroad.

*Those people (alternative practitioners) charge quite a lot. They do not write what's in the medicine. These hakims and vahids give patients tablets wrapped in a piece of paper just like in India. Then those tablets are passed from one person onto the other one from A to B. B hasn't been to the Hakim or anybody else so B has just taken the word from A. These are particular patients we find that tend to share their medicines. (P5, SA).*

*Some of them (complementary therapies) obviously are supplements they are not licensed properly and then they come and ask you. They go to their local medicine man and they get anything, now it could be copper or lead which are dangerous. Here, some people go to India or wherever and get it there but then what worries me it's like mixing the two, because their own doctors medication and they also hakims medicines. I don't think these medicines are licensed, but I think they get all of their ingredients from abroad and just get mixed here. (P3, SA)*

### **Hot/cold beliefs**

The 'white' participants were not aware of such beliefs. The South Asian pharmacists had varying explanations and said that this area was subject to interpretation. An explanation offered by a South Asian pharmacist (respondent 5) illustrates that 'hot' and 'cold' beliefs were those involving side effects of medication and more 'generation led' beliefs subject to translation and interpretation. This has also been shown in the study by Bhopal (1986). Community pharmacists interviewed did not routinely question their clients about these issues but it was more often mentioned by South Asians in 'casual' conversation. However, useful insights were divulged by one South Asian community pharmacist about the 'interpretation' of these beliefs in relation to side effects.

### ***'Side effects' interpreted as 'hot/cold' effects***

*Yes they describe it like that, they don't know exactly but they try to describe it like that. You never know. Is it because they are having side effects, are they too strong, is it psychological because they don't want to take it, is it too strong and they are having side effects when they start taking it? When I talk to them and say to them (to describe) what is a 'hot' medicine and what is 'cold' medicine in their mind. For instance if they take co-codamol tablets 2 four times a day they might 'stick' inside the stomach (pharmacists description). If they are used to eating hot food hot chilli food and then take 8 co-codamol a day and if they haven't eaten anything else all day and then have one hot 'chilli' meal at night that is going to give them a problem. Now when they find that they are constipated so it's a 'hot' medicine- a side effect, but it is due to their 'hot' medicine. Talk to them what do you call 'hot' and they say 'burning in stomach'. That's it! They are never ever going to take that, that's a simple example. They need a 'cold' medicine to counteract this side effect, such as an antacid. Another example is if they take Piriton tablets and they start sleeping and they find drowsiness it's a 'hot' medicine so anything with a side effect is a 'hot' medicine considered to be 'hot' so when we talk to them and they say the medicine is very 'hot' can I give them something mild as they are not going to touch the tablets at all. But give them Clarityn or Zirtek (non sedating antihistamines) they are happy because it is mild and hence 'cold'... no side effects.' (P5, SA)*

### **Extended family influences and generation differences**

All participants said that there were differences in the understanding of health beliefs between the older and younger generation but this was not unique to just South Asians. One south Asian pharmacist (respondent 4) said that influences of the older generation were prevalent in people living in the more 'traditional' cultural environment (reflexive diary entry after interview.)

Although the younger generations appear to have a better knowledge base and more awareness of current health issues, pharmacists were doubtful whether the younger generation were still being influenced by older family members and extended family cultures and beliefs. One respondent commented that the younger generation tend to emulate habits like the older generation but do not show it.

*'I think the younger South Asian generation know about what they should be doing and what they should be eating, it doesn't mean they necessarily take any notice of it but I think they have a better knowledge base, possibly because they have a total grasp of the language and the culture whereas maybe the older generations don't and possibly some of that problem is language related for the older generation because the health message won't be getting through in the same way'. (P1, E)*

*'...if you are living as an extended family then the diet is pretty much the same throughout the family and so these problems persist if that is the case and*



*obviously traditional and cultural things persist because it is what you are used to even if you then move away from the family home, these things tend to persist because it is what you have been used to.’ (P1, E)*

*‘....surprising enough some of them tend to still live it like their elder generation parents. Yet they do not show that they’re like their old parents’. (P5, SA)*

### **Fate and karma**

One respondent made a comment that a belief of ‘fate’ plays an important part in medicines concordance in this community. This was gleaned from her own experience of these beliefs and issues.

*Yes, it’s my personal experience, my uncle he is a heart patient, he doesn’t take all the medication, he is very strong willed and he believes in God, he says if I am going to get well it is my fate. (P3, SA)*

Such beliefs can pose a ‘dilemma’ for pharmacists to encourage medicines adherence according to the ‘universal’ model of care and it is useful to understand that such beliefs may be just an ‘expression’ of feeling. These issues were explored further with South Asian participants.

Theme 4. Communication
<b>Sub-themes (and categories)</b>
Use of interpreters and translators Use of Pharmacy staff
Patient counseling Use of leaflets Time barriers

### Use of interpreters and translators

None of the participants used professional interpreters or local services. Four participants were not aware of telephone lines and one respondent was aware of such services through personal knowledge. Family members were mainly used to translate verbal or written instructions mainly for people who could not speak English.

*If it was a question that I didn't understand in their language or sometimes I would ask them to bring somebody who knows English like a child who is at school or you know somebody who could explain. (P3, SA)*

*It's a problem that we facing recently quite a lot with migrants and asylum seekers. These refugees from Bosnia and Somalia who do not speak the language English and to communicate is very difficult. We have one or two families who live in this area and the husband or the little ones talk broken language we try and communicate with them using family members as interpreters. (P2, E).*

'White' participants also relied on counter staff who could speak the language for translation purposes. Counter staff who could speak the language were normally available and asked for help when needed.

*If counter staff actually come to us and bring to our attention that they (South Asian patients) don't understand what they are to do with the medication then we will make efforts with either the counter staff or dispensers or pharmacists who are there to explain it properly in their own language what they should be doing. Although they all speak different languages, there is usually somebody there who can converse even if not fluently (P1, E)*

There were clear concerns raised when probed about counselling on dosage instructions

*Sometimes the communication hasn't been as good as it could have been and sometimes I feel that I am not totally 100% sure that the patient has understood (P1, E)*

*'I would try and get the information across but I am not sure how successful I would be (P2, E)*

### **Patient counselling**

Pharmacists considered patient counselling to be part of their current role. All the participants discussed how they would prioritise patients for counselling, as all patients were not routinely counselled. One respondent admitted that she does not routinely counsel South Asian patients who do not speak English.

*We don't counsel unless they ask for help (P1, E)*

For patients who could not understand English, instructions regarding medication (e.g. on labels) was communicated using one or more of a variety of methods. Examples include:

- Translated leaflets with visual images (for asthma)
- Pictorial representation (clocks, numbers) for times
- Translated hand-written labels in different languages (either written on by the pharmacist or patient/representative)
- 'Sign' language
- Dosette boxes depicting different tablets and times to take them

All participants discussed that time is one of the important factors needed to educate, explain and reassure the patient.

*I try and make sure that each word I say is conveyed properly and if it's one tablet three times a day like morning, afternoon, things like that. But sometimes (with Bengali patients) when I cannot speak the language or have no staff to translate I would put my hands up and say 'go to a doctor'. (P3, SA)*

*I write Gujarati on the label as some people don't understand English. But it can be a big problem if they are illiterate and cannot read or write even their own language. (P4, SA)*

*Some people cope with numbers better than words anyway so if it's possible to indicate the number of tablets and a clock and that sort of thing you could write down some instructions in that way but apart from that it can be tricky. On few occasions I have added numbers to labels so that people know how many tablets to take and that sort of thing (P1, E)*

*We do draw little pictures, clocks. And that's how we communicate with them but then it's not a question of coming up to take plenty of water we show them the glass of water and everything or after food we show them the stomach and say after food. (P5, SA).*

It was acknowledged by all participants that patient information leaflets about medicines could be a useful means of communication if used pro-actively at the time of consultation and could give more weight to a verbal explanation, but very few participants admitted to using these. Examples were cited where leaflets were used included illustrating the use of inhalers for asthma, palliative care and head combing for head lice infestations.

*With some patient information leaflets particularly ones for asthma inhalers you have actually got ones with visual images which would probably be useful for somebody who didn't understand English (P2, E)*

*Translated Patient information leaflets are more for medicines that would be useful, because I am sure they would feel much more comfortable getting a leaflet and going away and reading it and then if there are any questions coming back to us about it. (P1, E)*

The time required to communicate appropriate messages was considered to be one of the main barriers to effective communication with the S. Asian ethnic minority patients. Problems were seen with both the older and younger generation. One of the reasons for this is because of language problems. One South Asian respondent illustrated this point, even though he could speak an Asian language.

*Time is a big barrier for effective counselling. Realistically, I cannot spend so much time with them (Asian patients who cannot speak English) much as I'd like to. (P5, SA)*

*They (South Asian patients who do not speak English) require a lot of time to explain things properly to them (P4, SA).*

Theme 5. Education, information and health promotion
<p><b>Sub themes (and categories)</b></p> <p>Training on ethnicity, cultural beliefs and attitudes</p> <p>Knowledge of population demographics</p> <p>    Computer records of patient's ethnicity</p> <p>Health promotion (education and communication)</p> <p>    Leaflets for health promotion</p> <p>    Use of media (as education and communication)</p> <p>    Project Dil</p> <p>Promotion of pharmacists role</p>

### **Training on ethnicity, cultural beliefs and attitudes**

Three of the community pharmacists were from South Asian background and relied on their own knowledge of cultural issues. However, there was disparity whether further training on these issues (apart from language barriers) could affect their role in promoting new initiatives.

All the pharmacists were aware of the dietary habits/restrictions of certain patients through their own knowledge (see previous theme), and had received no formal training on cultural issues. Two 'white' participants (1 and 2) admitted they had very little understanding and knowledge of religious or cultural beliefs such as fasting and dietary habits. The three Asian participants (3, 4 and 5) relied on their own knowledge on relevant cultural aspects. This 'lack of knowledge' on cultural issues' was not perceived to be a barrier to the service they provided in the pharmacy. Three pharmacists had knowledge of at least one South Asian language. All pharmacists relied on their own knowledge of ethnicity and diversity issues and the population demographics of the area where they worked.

All the pharmacists employed counter staff from South Asian ethnic backgrounds that helped in the consultation process although none of them had received any formal training on cultural issues. The two 'white' participants were positive of the benefits of such training if it was made more relevant to health service provision.

*Information about other ethnic groups or cultures, having a little bit of all of the topics covered would be of benefit (P2, E)*

## **Knowledge of population characteristics and demographics**

None of the participants had definitive knowledge of their local patient population characteristics e.g. ethnicity status or population numbers. All participants 'estimated' the percentage of South Asian service users that used their pharmacies. Table 26 page 231). During the period when this research was conducted, it was not routine practice for community pharmacists to capture information around ethnicity, language or cultural background of the service users in their medical records. No information on cultural or ethnic issues was captured on Patient Medical Records (PMRs). Pharmacists were asked whether this information would be useful how they would use this information.

*I don't know what way we would use it exactly if we had that information. There is probably a lot more we could do but we don't do, at the moment I don't know whether or how it would be useful. (P1, E)*

*I think it would only be useful for people who wanted to see what percentage or customers from particular ethnic backgrounds but the day to day running I am not sure it would make that much difference'. (P2, E)*

One pharmacist thought that computer information on preferred languages spoken by the patient and their cultural background were thought to be of benefit to locums from non-Asian backgrounds.

*I think which language they speak but basically that is the most important. If these locums who are not from ethnic minority if you had locums from any other background, like English locums or anything like that then yes because they would have some idea, but then if they can't speak the language anyway it is no good to them anyway.(P4, SA)*

To date there is still no requirement for community pharmacists to capture data on the patients' ethnicity on the medication records held in community pharmacies. The author suggests that this information is fundamentally needed to ensure that a more meaningful, targeted and equitable service can be provided if this information was available. Data capture of ethnicity and cultural background and beliefs could enhance long term disease management of South Asian patients by GPs and community pharmacists as set out by national guidelines and frameworks. If the ethnicity and cultural background of users were effectively captured, this could also enable health care professionals including community pharmacists to probe into aspects of cultural habits that affect health beliefs and medicines adherence (e.g. the fast of Ramadan, the use of complementary therapies etc which is discussed later in this chapter). In addition, this would be valuable information for audits and evaluations for the monitoring of health seeking patterns

and behaviours as well as enable appropriate monitoring of long term conditions by community pharmacists. Most community pharmacy computer programmes do allow 'notes' to be made on the PMR about particular issues relating to medicines use. Such records could help with counselling, and improve the pharmacists understanding of particular medication needs for that patient. Capturing such data could also be used for community pharmacy practice research and more targeted health education and promotion. The study by Jesson et al (1994b) also acknowledges the difficulties in the collection of ethnicity data from standard population databases available, and endorses the importance of this information for the purposes of research into the health care needs of this community.

### **Health education and promotion**

All participants reported that they were not aware of health promotion campaigns run by the local PCTs and that this was an area that they had to have support to engage with.

*Pharmacists are not aware of health promotion campaigns. At the moment PCTs are just struggling. Pharmacists themselves are trying to do the best for their patient whoever he or she may be and they are just trying to do the best for themselves. But there is no other support for health promotion from community pharmacy (P5, SA)*

All participants stocked relevant leaflets for health information health promotion. This is a mandatory requirement in the pharmacy contract. The uptake of health promotion leaflets was passive and patients relied on a 'less busy environment' if they wanted more information about the leaflets and their content. Time and appropriate support were cited as important factors needed for effective health promotion using leaflets.

*They passively pick up a leaflet it is very difficult actively promoting leaflets. There is a time factor in a busy pharmacy to promote the use of leaflets for communication. Unless patients come at times when we are not busy, we do not promote leaflets (P5, SA)*

All the participants needed more information where to source appropriate translated information but recognised that practically they would not have the space to stock them.

*You would need a very big rack to have everything in every single language, but it would be nice to think that some information was there in other languages. A 'sign' saying that 'if you need information in another language we have got it' that sort of thing would be good. (P2, E)*

During data collection, the investigator noted that leaflets appeared haphazardly arranged and disorganised in many community pharmacy (and GP) practice settings. Community pharmacists alluded that they were not aware of where to get translated leaflets when needed.

The uptake of displayed patient information and health promotion leaflets was not evaluated or monitored. Some participants commented that many patients do not value leaflets, including leaflets in other languages.

*They (translated leaflets) were good but how many read them I don't know and I know many of our people bin them. Yes, some of them actually look at them and take them. A lot of them are binned. Children use them as scrap paper (P4, SA).*

*I have not seen those (translated leaflets) much so I doubt it if anybody uses them. I would imagine they are fairly obsolete personally, I don't know how many people of the whole population go round reading patient information leaflets (P1, E)*

One respondent commented that the content of leaflets made it difficult for patients to read or understand the information.

*The language in them is sometimes difficult anyway and even if you are well versed with the language sometimes people don't understand what is trying to be said in them anyway, and so if you are from a population and your understanding of written English is poor then I doubt that you would even try to read them (P1, E)*

Participants said that leaflets, including translated leaflets should be available for targeted health areas and appropriate services for the South Asian population.

- Heart disease
- Diabetes
- Arthritis
- Children's health
- Travel health
- Coughs/colds, simple minor ailments
- Translated leaflets for depression, 'private' illnesses
- Prevalence of smoking in Asians

*I suppose particular areas that are specific to the population so, I suppose it (a translated leaflet) would be helpful really, we were mentioning about discussing things like depression and more private illnesses **probed to elaborate...**for example...asthma for example-they rarely want us to explain inhaler technique*



*because they do not want to be seen to use the inhaler, but also to communicate inhaler technique would be a bonus ..... if you like it would be nice to have leaflets for that sort of thing. (P1, E)*

Participants commented that health promotion using television and media services was thought to be an effective way to communicate and promote health to this particular population. There was cautious comment by pharmacists on the use and availability of the usual audio-visual methods (videos etc) which should be used together with other alternatives rather than as a sole method. However, they indicated that more specific targeted messages were needed in different languages.

*I think it (using videos) could be a good way, although I don't know quite how it would work. I think if you are going to do something like that I think you need to be working in a situation where you can gather people together to look at information and you can discuss it afterwards. I think in a pharmacy situation such as ours wouldn't be possible. (P1, E)*

*Health promotion messages (via the radio or TV) would depend on the individual whether they had time to view it, if they are living in big families as all ethnic minorities do you know how it is they want to watch something else. (P3, SA)*

*There is no value in videos for health promotion running in health centres. I know this from experience because they have this in the surgery and they have a monitor and it's amazing how many watch it or take any heed of it (SA, 4)*

None of the participants were involved with Project Dil in Leicester City and three participants had not heard about the initiative. Clearly, the lack of communication can lead to a gap in information on the use of medicines and perhaps communication on the importance of medicines adherence. But more worryingly, the gap in how health care information is given to South Asian patients with linguistic challenges adds to the debate. The introduction of the sharing of electronic patient recording via the National Programme for IT (NPfIT) in 2005 was introduced to enhance this process as part of the NHS Plan (DH, 1998) and the recommendations of the Wanless Reports for public health initiatives (Wanless, 2002, 2004 and 2007). The findings show that the recommendations have not been 'translated' into meaningful 'actions' in the community pharmacy setting, and this is further explored with South Asian participants.

#### **Box 14 . Key Findings from the pharmacist interviews (Phase 1)**

- Pharmacists said that stigmatised conditions such as depression and contraception were not easy to discuss unless trust and confidentiality were assured.
- South Asian pharmacists relied on their own knowledge of how cultural issues (such as fasting, the interpretation of 'hot and 'cold' symptoms as side effects) and how to overcome these actors in relation to adherence.
- Some South Asian pharmacists described how they would overcome counselling barriers (for example through use of pictograms) but this practice was 'personalised' to particular pharmacists and individual circumstances.
- Pharmacists commented that their role was not promoted as a health care professional, but rather as a shopkeeper and a dispenser of medicines.
- Pharmacists commented that they needed more time for meaningful consultations with South Asians and consideration for adequate remuneration was needed to reflect this
- Cost of purchasing medication was a key barrier to pharmacists being used as a first port of call for minor ailments
- 'White' participants did not consider that their lack of knowledge of cultural issues was considered to be a barrier to services
- Pharmacists did not think that the use of alternative medicines and practitioners contributed significantly to the overall health problems in this community.
- None of the pharmacists had any formal education training on cultural issues or the demographics of their patient population.
- Information provision on travel health in addition to the well-known areas such as diabetes and CHD were also suggested useful and where a positive, pro-active contribution to patient education could be delivered in a community setting.
- Concerns were raised about the usefulness of translated leaflets as there was doubt if the leaflets were actually read by the patients.
- None of the pharmacists were actively involved in local health promotion campaigns for this population
- Weight and diet, diabetes, heart disease, coughs and colds, pregnancy and aspects of travel health were cited by participants as main areas of health promotion and advice that was needed for this population.

Many of these findings are consistent with the findings in the pharmacy literature. Difficulties encountered with mental health consultations, contraception and 'stigmatised' conditions with South Asians appeared to be a new finding which was not found in the study by Jesson et al (1994b) and warrants further exploration with South Asian focus group participants. Common findings with the data from the interviews with GPs include the perception of the pharmacist as a 'shopkeeper' and the views of pharmacists themselves about how GPs perceive them to be shopkeepers. It was not apparent from the findings that pharmacists' role was 'changing' as a result of the government changes in policies. The limitation of the findings from pharmacists is that 'saturation' was not reached in order to be able to make conclusive comments about these aspects. Nevertheless, some of the 'cultural' aspects affecting medicines adherence and the reasons for the perceived 'non-acceptance' of the community pharmacist as a health advisor need to be further explored with South Asian community members. An inference relating to the provision of 'social marketing' of pharmacy services also emerges, as the findings illustrate the need for more information 'targeted' for this particular population.

### **SECTION 5. 3. Discussion of the findings from Phase 1**

At the time of the first phase interviews (2001) it was relatively difficult to cite appropriate evidence based literature on the topic of South Asian health and cultural influences in relation to pharmacy practice. Much of the literature was in specialist repositories which GPs and pharmacists would not routinely access for information during their daily practice. Despite the availability of the medical and sociological literature available on this topic, both the GPs and community pharmacists interviewed in this study demonstrated lack of knowledge on these issues. The findings of this PhD study illustrate that better awareness is needed on clinically significant consequences of cultural beliefs of ethnic minorities on their health. In the author's opinion, this could lead to a better consultation experience both for GPs and community pharmacists.

All GPs and community pharmacists were aware of the health and disease issues affecting the South Asian populations, particularly diabetes and cardiovascular disease and correlates well to wider literature reviews on the health of South Asians in the UK. Other disease areas are mentioned in the literature, but participants did not discuss these in the interviews. Although all GPs and South Asian community pharmacists were aware of how specific cultural influences, such as diet and lifestyles, fasting and the use of alternative medicines could affect the management of long term conditions such as hypertension, coronary heart disease and diabetes, most Asian community pharmacists and Asian GPs did rely on their own knowledge about some of the issues around the awareness and management of these conditions. Since the time of data collection in 2002, there have been some guidelines published for clearer implementation strategies to deliver the recommendations of the NICE guidelines and the National Service Frameworks specifically for the South Asians (e.g. Fox, 2004, Patel and Bhopal, 2004; Patel and Shah 2005), but the precise contribution that community pharmacists could make is still unclear.

The findings of this study demonstrated that community pharmacists and GPs needed to improve their own knowledge of their population demographics and cultural influences that affect health seeking behaviour. What appears to be lacking at the time of data collection (2001-3) was a 'pharmaceutical needs assessment', particularly for the pharmaceutical needs of the local population. Establishing an ethos that the GP practice or community pharmacy practices are aware of the diversity of the local population it serves, can help in underpinning good patient care. However, the findings show that data is not captured regarding the ethnicity

of patients and this could be a barrier in developing more targeted approaches, as health and pharmaceutical needs are currently based on 'biomedical' models of health promotion and consultations rather than 'population' needs.

The reliance on consulting the GP for 're-assurance' by way of a diagnosis was an interesting finding from the perspective of 'white' GPs, who also commented that this may not be 'unique' to the South Asian population. Research on the management of minor ailments in community pharmacy have studied the 'white' population, and the methodologies adopted mainly result in improving 'access' to GPs by freeing up appointments that would have been booked for patients with minor complaints. Although the findings of the studies by Whittington et al (2001b, Chapter 3 page 70), Hammond et al (2004), and Bojke et al (2004) show that a significant number of minor ailments could be managed by community pharmacists, their findings did not capture whether the consultation patterns were different for ethnic groups. The findings of these studies did not demonstrate an improvement in the patients' knowledge of the management of minor ailments, nor did the results show that the health advisory role of the pharmacist was enhanced through such schemes. The findings of the study by Whittington et al (2001b) and Bojke et al (2004) cannot be considered to be generalisable to other settings with differing population characteristics like Leicester City except to say that such services may be able to improve access to medicines which would otherwise need to be purchased. In a later study by Pumtong et al (2008), the findings show that although the minor ailments scheme (introduced in Nottingham) was well received by community pharmacists, issues such as lack of privacy, the added burden of paperwork and the restrictiveness of the protocols of the scheme were potential barriers to the success of the scheme. Pumtong et al (2008) also showed that patients preferred to have consultations for minor ailments in a private consultation area; a notion that was also raised and discussed by GP participants. This finding is also explored further with South Asian participants in the next phase of this PhD study.

A new finding for pharmacy is the problem of talking about presentation of stigmatised conditions such as depression, and South Asian pharmacists gave further insights into such issues. This aspect warrants further exploration in future pharmacy practice research studies.

### ***Medicines adherence***

A major finding in this phase of the study is the possible explanations that may underlie observed health behaviours with respect to medicines adherence. The impact of the fast of Ramadan on patient compliance and concordance has been discussed in the pharmacy literature, but many of the earlier studies utilised poor methodologies and did not discuss the wider impact this had on the holistic health beliefs of this population. More robust research has been published in the medical domain (e.g. Aadil et al, 2004). Knowledge of patients' cultural interpretations during the fast of Ramadan is explored further in Phase 2 of this study. All the participants in Phase 1 of this study relied on their own knowledge of these issues in helping patients to interpret and help overcome patients' perceptions of non adherence during the fast of Ramadan. Interestingly, less attention was paid to other aspects of 'permissible' medications in this PhD study e.g. porcine medications although senior religious leaders have collaborated to provide guidance on this issue (Mynors et al, 2004). Moslem GPs re-iterated the importance of involving religious leaders and significant community members to endorse reasons for abstaining from fasting in this period.

Even though participants relied on their own knowledge regarding the use of non-Western complementary and alternative medicines, all participants were either unaware or non-committal on issues surrounding compliance and concordance with these products. However, knowledge and additional information pertinent to the clinical significance of potential problems using such products was welcomed by pharmacists and GPs. The study by Jesson et al (1994b) confirmed the use of these modalities by South Asians, and that many of these were in fact simple 'home' remedies. The findings in the literature (Kayne (2002) and Barnes (2003)) have shown the importance of 'quality assurance' of complementary therapies, including those available from the Indian sub-continent. In addition, significant drug interactions have been illustrated in the literature (e.g. Miller, 1998; Williamson, 2009). Studies by Bhopal et al, 1986; Moody et al, 1998; Ali et al 2005; Rhodes et al, 2008 illustrate that health care professionals need to be aware of the use of complementary therapies and the clinical significance of using such products, as well as the awareness of the use of alternative practitioners by this population group. It has been suggested that a negative attitude toward 'alternative' or 'folk' medicine and healing rituals on the part of a health professional may be perceived by South Asian patients as a direct attack on religious or cultural beliefs and lead to mistrust, and that careful questioning of such practices needs to be discussed through open questions exploring health beliefs and

practices, engaging patients in a more meaningful way. These issues were also explored in Phase 2 of this study.

The literature also shows some emerging evidence on variations of 'ethnic' responses to certain drugs (Wood and Zhou, 1991). This was not explored in this Phase of the study and did not appear to emerge from the discussions with community. However, it is an important consideration for future study and should be explored in a consultation or medicines review.

### ***The argument for training on 'cultural' competence***

The idea of GPs and pharmacists to be trained in having appropriate 'cultural' knowledge and 'cultural competence' has been debated in the literature. It can be inferred that the findings that GPs and community pharmacists need to demonstrate 'competence' in delivering appropriate services tailored to their population needs. There was variability in the responses obtained from GPs and community pharmacists in this study about their background knowledge of their local population demographics and cultures, showing a need for both community pharmacists and GPs to update their knowledge on such issues through on-going professional development. Since 2009, continuous professional development (CPD) is now a mandatory requirement for all practicing pharmacists to demonstrate fitness to practice.

None of the major government reviews and policies (Chapter 2) mentions the specific role of community pharmacists in relation to health inequalities in the UK. However, evidence from the wider literature identifies that some of the explanations advanced for the failure of health professionals to meet the needs of ethnic minorities include lack of understanding of cultural diversities, racism, racial stereotyping, and lack of knowledge, exclusiveness, and ethnocentrism. (Bissell and Jesson, 2002; Bissell et al, 2003b, Puri et al, 2003). In addition, it cannot be assumed that just because a healthcare professional is from a South Asian background, they have knowledge of South Asian cultural beliefs. The findings of this study do however relate significantly to lack of knowledge of health inequalities by community pharmacists. Little work has been carried out to examine these issues from the perspective of community pharmacists caring for ethnic minorities in the UK. The NHS White Paper for Pharmacy (DH, 2003a) and the Pharmacy White Paper for Public Health (DH, 2005a) show that community pharmacists need to be engaged in public health activities and mention the need for community pharmacists to be engaged with the health inequalities agenda. It can be argued that a greater awareness, knowledge and the motivation to do something about these issues is

needed by community pharmacists for their services to be meaningfully delivered to populations including BME groups. However, areas such as cultural influences on health and health seeking behaviour were explored in this study and the latest Pharmacy code of ethics (RPSGB, 2007b) is explicit about these issues. Bissell and Jesson (2002) show that community pharmacists need to engage better with the emerging health policies related to health inequalities and understand the root causes of health inequalities rather than focusing on the behavioural arguments for health inequalities (such as smoking, drinking, healthy diets etc). The findings of this PhD study confirm a need for better engagement by community pharmacists in this area, further validating the argument put forward by Bissell and Jesson (2002) that by moving away from a traditional 'bio-medical' model of services delivery, a greater focus should be placed in the inclusion of socio-behavioural models into pharmacists' training. Puri et al (2003) also confirm the findings that community pharmacists need have better awareness of these issues. The author of this study recognizes that this is a limitation of this PhD study as she did not explore the 'wider' issues on health inequalities in more detail with the participants. The present concern with the 'wider determinants of health' encapsulated in the Marmot reviews (1984, 2010) was not then (at the start of this study) a major focus of policy, nor can it be addressed in a qualitative study of this sort, since much of the argument on socio-economic inequity concerns relative relationships and statistical data on correlations, rather than concerns about the causation of individual behaviour. The findings of this PhD study however do illustrate that 'competency' of healthcare professionals (cultural or otherwise) needed to be re-appraised to be revalidated in light of the new policies.

### ***Professionalism and recognition of professional status***

The NHS plan (DH, 1997) and related government policies explicitly state the need for effective inter-professional education and collaboration as part of the wider strategy in the delivery of the new NHS agenda. The findings of this study can be further interpreted that there is a need for initiatives to enhance the recognition of the professional roles and responsibilities within undergraduate curricula. Examples of such initiatives have been illustrated in the literature (Barr, 1998; McNair, 2005). For pharmacy, an example of the integration of an inter-professional education (IPE) module has been successfully integrated into a pharmacy undergraduate programme (Lakhani and Anderson, 2008). The literature shows that challenging the autonomy of GPs and the lack of collaborative working has been shown to be detrimental in improving relationships. The findings of this PhD study correlate well to the study by Hughes and McCann (2003), Seamark (2003) and Hammond et al (2004) (see chapter 3).



Their findings add further validity to the data of this PhD study. It can be inferred that lack of acknowledgement and perhaps 'misinterpretation' or 'subordination' of the community pharmacists professional role appears to be an important factor in the message given to patients from GPs, leading to under-utilizing the community pharmacist as a health advisor rather than shopkeeper and dispenser of medicines. It was only when GPs were asked about potential extended or clinical roles that some GPs were more positive to embrace such ideas after further explanation of these roles by the investigator of this PhD study.

Effective collaboration between GPs and community pharmacists underpin the new policies in the NHS reforms and are the mainstay of the recommendations within the policies. As pharmacists are being promoted as an accessible health care professional on the high street, it is important for pharmacists to embrace such initiatives as part of their professional development. Bond, Blenkinsopp et al (2007) have shown that certain aspects of the pharmacy contract have been well received and implemented, including the introduction of private consultation areas. These findings enhance the data from this PhD study where the data was collected in 2003. They also added that whilst having these areas could enhance the notion of 'professionalism' in the community pharmacist, the added training requirements and remuneration structures would also need to be in place for them to effectively deliver the services and see a return on their investment. Pharmacists also re-iterated that for new services to be delivered, more time would be needed for performing extended services such as Medication Use Reviews (MURs). The need for appropriate remuneration for extra time has been endorsed in the new contractual arrangements for community pharmacy (DH 2005) for Medicines Use reviews (MURs). However, the findings clearly suggest that the image of pharmacy remains the same, more of a commercial enterprise. Further studies by Hassell (2006) also confirm that pharmacists are more 'stressed' since the introduction of the community pharmacist contract in 2005, and the evaluation of the new Pharmacy Contract (Bond, Blenkinsopp et al, 2007) add to these findings.

Much of the literature in this area (Hughes and McCann, 2003; Edmunds and Calnan, 2001) argues pharmacy's position as 'subordinate' to medicine as a key factor restricting professional status. In addition, it is also suggested that that pharmacists are at risk of being 'isolated', and this contributes to the debate on 'professionalism' (Cooper et al, 2009). However, the author of this PhD study argues that this could be eased where trusting relationships can be established. The GPs in this study were prepared to be 'educated' about the potential

contribution that could be made using community pharmacists, but this would need to be further researched. The introduction of pharmacists as 'supplementary' and 'independent' prescribers advocated by the government (DH, 2003b ) in enhancing 'professionalism' particularly in the community pharmacy setting still remains under-researched. Jesson (2002) and Bissell (2006) illustrate the argument for and against 'social marketing' of community pharmacy services and the scope of community pharmacists providing specific "social" roles and becoming 'social entrepreneurs' by linking with local trusts and community groups, thus addressing issues that are fundamental to a community's health. This notion is further explored with South Asian participants in Phase 2 of this PhD study.

The findings from an SDO report in 2010 (McDonald et al, 2010) also criticised that the recent reforms in community pharmacy which offer financial incentives to undertake additional tasks, do not provide opportunities for pharmacists to extend their roles and enhance their status. The findings of the report suggest that it can have unintended effects which may be damaging to the profession. The study by McDonald et al (2010) also shows major divisions within the profession, including negative effects of MURs such as the creation of a target driven 'tick box' culture and increased dependence on patients for 'business'. Although the data for the current PhD study was collected much earlier, the inference of the findings of this PhD study shows that not much has changed, and that further research needs to explore other ways which the 'professional' recognition of community pharmacy can be better achieved.

Government policies outline 'frameworks' underpinned by 'examples of best practice', with the intention of moving pharmacists towards a more clinical service oriented role. Whilst such examples are commendable, this author of this research study suggests that in order to deliver this NHS vision, there needs to be clearer leadership and resources allocated for community pharmacists to deliver on these highly ambitious plans. However, the findings of this Phase of the PhD study and the wider literature has shown that the perception of the community pharmacist has moved at a glacial pace since the Nuffield report (Committee of Inquiry, 1986) and that very few of the recommendations of the study by Jesson et al (1994b) have been translated into improvements in service delivery or outcomes. Recent reforms to encourage greater use of pharmacists' skills appeared to have done little, if anything, to change that. From the findings of this PhD study, there is a clear need for effective promotion of the role of the community pharmacist as a health care professional to members of the South Asian population, but the author of this study also advocates the re-appraisal and further research of this role for

all members of the general public, and to explore why this is still the case. The findings of this study also how an 'anxiety' of community pharmacists as to how 'new' services could be delivered without a radical change to their contractual obligations and remuneration policies, and this could be further confounded by the recent change in Government (May 2010).

The findings from Phase 1 were further explored with focus group members from the local South Asian community, including those from the Sikh, Moslem and Hindu faiths. It was envisaged that South Asian service user interviews would add to and enrich the findings from the GPs and pharmacists for the author to have a more meaningful discussion about the issues and questions for the research study. The findings give the reader further insight in understanding how this population uses community pharmacy services and what barriers they perceive and experience, which they use to judge and value these services.

# Chapter 6

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## **Phase 2 findings and discussion The views of South Asian service users**

## CHAPTER 6. PHASE 2 FINDINGS AND DISCUSSION

### The views of South Asian service users

Following the findings of Phase 1 of the research, the researcher sought the views of a selection of South Asian members of the public about their experiences of community pharmacy services, and whether there were any cultural issues that influenced their health and health seeking behaviour. **(interviews done in 2003)**. The themes identified from the Phase 1 findings with GPs and community pharmacists were explored further.

This chapter is divided into the following sections:

**Section 6. 1.** The emerging themes from Phase 1 were further explored with South Asian service users. Findings from six focus group discussions with fifty five South Asian service users are presented.

**Section 6. 2:** Findings of the revalidation exercise done in 2008 to confirm the findings and analysis of the interviews conducted in 2003. The interviews include in depth interviews with one GP, two community pharmacists and a focus group interview with six community members from the South Asian community.

**Section 6. 3:** discusses the findings from Sections 1 and 2.

The researcher has used the following terms in the description of the findings throughout the research report and recognises the subtle differences between these terms. They include:

- South Asian participants = South Asian respondents (doctors, pharmacists and focus group participants)
- South Asian patients = South Asian service users (focus group participants)

## SECTION 6. 1: Phase 2 Findings of focus group interviews

Six focus groups (gender and culture specific) from the Moslem, Hindu and Sikh communities were convened and conducted in community centre in Leicester.

**Table 30. Profiles of focus group participants**

<b>Focus Group</b>	<b>No of participants</b>	<b>Age range</b>	<b>Religion</b>	<b>Gender</b>	<b>Setting</b>	<b>Interview Language</b>
1	8	41-60	Hindu	Female	BNC	Gujerati, Hindi, English
2	9	42-75	Hindu	Male	BNC	Gujerati, Hindi, English
3	8	44-90	Punjabi (Sikh)	Female	EPRG	Punjabi
4	11	53-90	Punjabi (Sikh)	Male	EPRG	Punjabi
5	7	30-70	Moslem	Female	KCC	Gujerati, Kacchi, English
6	12	28-75	Moslem	Male	KCC	Gujerati, Kacchi, English
Total	<b>55</b>					

BNC: Belgrave Neighbourhood Centre, Leicester

EPRG: East Park Road Gurdhwara, Leicester

KCC: Khatri Community Centre, Highfields, Leicester

Detailed focus group demographics can be found in Appendix 4.

### **Box 15: Aims of Phase 2 focus group interviews**

- To consider the views of members of the public from South Asian ethnic minority background on current pharmaceutical services
- To explore their beliefs and views (including cultural) relating to their health and the use of medicines
- To explore their attitudes for the management of minor ailments
- To explore what barriers they encounter when seeking health advice
- To explore their views on future initiatives for community pharmacy services

Fifty five categories were identified from the interviews and these were grouped into six themes:

- Perceptions of health and influences on health
- Views on GP services
- Views of community pharmacists and the services they provide
- Communication issues
- Cultural beliefs influencing decisions on health
- Views on education, health information and health promotion

Each of these themes are discussed below, supported by quotes from the focus group participants. A table of each theme and accompanying 'categories' is presented, highlighting which focus groups mentioned or discussed their ideas; this supports the researcher's findings of 'deviances' within the categories and themes.

**Theme 1: General perceptions on health, what influences health and health seeking behaviour**

Participants	Hindu female (HF)	Hindu male (HM)	Punjabi female (PF)	Punjabi male (PM)	Moslem female (MF)	Moslem male (MM)
Themes/Categories						
• <b>Theme 1: Health and influences on health seeking behaviour</b>						
General health	✓	✓	✓	✓	✓	✓
Diet	✓	✓	✓	✓	✓	✓
Lifestyle	✓	✓	✓	✓	✓	✓
<b>Factors affecting health and medicines adherence</b>						
Weather	✓	✓	✓	✓	✓	✓
Stress	✓	✓	✓	✓	✓	✓
Prescribing issues		✓	✓	✓		✓
Sharing medicines						✓
Drug waste						✓
'Fate'			✓	✓		✓
Health abroad	✓	✓	✓	✓		
Compliance abroad	✓	✓		✓	✓	

✓ : means that this was mentioned

**General health**

Participants were asked if they considered themselves healthy and how they defined health. All participants either had significant health problems themselves or were in contact with family members who had significant health problems including coronary heart disease, diabetes, chronic kidney disease, musculo-skeletal problems and mental health issues. Most participants knew the conditions they or their family members were suffering from without being probed. The groups describe their problems as 'small' or 'big', which the researcher interprets to be 'major' (big) and 'minor' (small).

*Everybody has to suffer small or big problems (HM1, 71 yrs)*

Some of the more elderly participants were not clear about their health and the associated conditions

*I suffer from 'noises in the head' and GI ulcers. I am taking Gaviscon for this. I also suffer from arthritis and some 'heart' problems. (MM11, 66y)*



Comments about minor ailments were obtained throughout the study. More general comments were made about the older members of the focus groups

*For minor ailments we tend to sort ourselves out (MM 2,3,5,6,7,11 aged 30-75)*

*I have only been to the GP once in two years. I tend to ignore minor illnesses I automatically get better. I tend to ignore minor coughs and colds. (MM5, 75y)*

When asked about how they managed their problems, some interesting comments were made by the participants about community and family support.

*'Live with it' –that's what they say (MF 3, 42y). (When **probed** by the researcher to explain who 'they' was, the indicated that it was friends and community)*

*I live with my blind son who looks after me. Till late have always done my own shopping and housework. I think my problems-headache; general aches and pains, indigestion etc and he says that they are all age related. It's now a bit difficult and perhaps I should consult my GP on this. I need someone to Hoover now because I get breathless. Perhaps my GP can advise me on what I should do, but I rely on my son to take me and also understand what the doctor says (MF5, 70y)*

All the participants commented about the causes of ill health and the health of their children. It was also apparent that the participants wanted more knowledge of what the reasons were behind their health problems.

*My children suffer a lot from allergies and asthma. Ear problems also-all connected aren't they? We control the pain with Calpol. Despite changing floors and carpets etc-still persists. Is this due to pollution-it is a concern to me. (MF 3, 42y)*

*'Flu with the kids is a problem. Also asthma-cannot explain or understand this. Eczema is also a problem, particularly in children, despite being given cream. (MM1, 30y).*

*Since I have come here, young and elderly women and even men are all complaining that their legs hurt a lot. What can be the reason for this? Wherever you go, you see women from the age of about 30-legs are giving up. But the knees-this is becoming a big problem (MF 3, 42y)*

*It's the younger generation that are more concerned about their own health. The older generation need not only to be told (about health issues) but to be convinced that they are suffering and that they need to look after themselves.*

*They are the ones that need targeting. **Probed....by whom?** By the health service. (MF5, 70y)*

Most participants relied on discussing 'general health' issues with friends, family and more 'community' based events, and there was no mention of getting any advice from a community pharmacy for general health concerns. It is interesting to note that some symptoms were considered 'minor' and it will be discussed later in this chapter that a deeper probing was necessary for the participants to clarify this further during the interview.

### ***Diet and lifestyles***

Most participants did have reasonable beliefs that diet and lifestyles could contribute to their health and well being. It was noted, however, that the Hindu female participants were very quiet about this topic only mentioning that their diet needed to improve. Comments were made about lack of vitamins in vegetarian diets. Punjabi female participants were very concerned about the lack of 'natural foods' and the use of 'fertilisers' that could affect the quality of food and demonstrated variable 'theories' regarding this.

*If you give child too much to eat and there is a sudden growth spurt-is there something in the food? Is it a side effect of fertilisers? Or chemicals? Or are there 'hormones in the water?'*(PF1, 90y) (literal translation and interpretation by the Punjabi speaking moderator: confirmed by back translation)

*If there is a lack of sunshine- then there is a lack of Vit A and D in the body. This is due to the weather here and this can lead to soft bones. (PF2, 67y).*

Some interesting concepts were discussed by other participants. Comparisons were made between the quality of food in the UK and their country of origin. In addition, Punjabi female participants placed an emphasis on the greater degree of physical exercise involved in work within the country of origin in comparison with that of Britain. Most participants acknowledged that they ate 'heavier' diets in the UK, and coupled with lack of exercise, this could lead to health problems.

*There is a clear problem with diet and lifestyle in our Asian community. (MM6, 48y)*

When prompted about exercise, all participants engaged positively about this concept. The interviewer did question participants about what 'exercise' meant for them and how they interpreted the meaning of 'at least half an hour of exercise three times a week'. An excerpt

from the conversations with male Moslem participants and the same concept with female Moslem participants illustrates the power of 'peer' influence on this subject.

***Group interaction about 'exercise' between male Moslem participants***

*We do not exercise at all. I have never had a chance to do any exercise because of a busy family lifestyle (MM11, 66y). Depends on time availability.*

*We all know exercise is good for you. But we just do not do it (MM8, 28y).*

*I am just not bothered (MM9).*

*I do not exercise and I do not know the true meaning of 'exercise' (MM11, 66y)*

*Even though people say they exercise, they do not. They watch TV all day. They do not know the true meaning of exercise (MM11, 66y and MM2, 30y). ALL AGREED.*

Moderator explained for example half an hours exercise 3 times a week

***Reactions:***

*Nobody exercises that regularly (all participants' contribution).*

*We used to do that when we were younger. People now would rather watch TV than do exercise. This is something about our 'make-up'-we just do not do it (MM4, 5 and 6 ages 45-75y)*

*I agree with you (i.e. the participants). I am diabetic and I am supposed to exercise. But I know I do not do it. I say I do but don't-in the true meaning of the word. I consider myself active by doing gardening-I consider that exercise-I do not have a fixed time or anything (MM4, 45y)*

**Group interaction between Moslem female participants about diet and exercise**

*I watch my diet, right? Although Doctors tell us what to do and not do, eat and not eat etc about diabetes, people still do not follow this advice. (MF1, 30y)*

**Why is that? (probe)**

*Its will power isn't it? It's what we've been brought up with-eating how we are. Even though we have been advised about what oils we should use and the choice of oil, many people still cannot adjust. (MF1, 30y and MF5, 70y)*

*So is sunflower oil better than the rest? (MF6, 47y)*

*Yes it is (MF5, 70y). Better than any other (MF3, 42y)*

*Doctors are always advising about diet. I love my salt. I was told to cut out my salt from my diet because of my blood pressure. I was recently very ill. But, I found it very difficult to do this! But I tried reducing it by half and I felt a lot better! It has made a lot of difference to my health. Drs have told me it is because I have cut down on my salt. (MF2, 33y)*

*When my son was young he really suffered from asthma. He is 19 now and off all his pumps. We did everything-I changed carpets and floors and cooking habits also. I found that frying foods and cooking oily foods set him off. I think nowadays junk foods contribute to bad health and weight gain. Youngsters are eating more and more junk foods. There is a big problem here. (MF3, 42y)*

*You have to look after your diet to be in good health. I do regular exercise (probed-what?) Walking. I have not had sugar in my food for 19 years! Even then, I still have high blood pressure. It frightens me (MF7, 61y).*

*I cannot cut down on sugar. I love it and I crave for it (MF1, 30y).*

*I don't have any cravings but in my mug of Indian tea I must have my sugar-one teaspoon, not Canderel (MF5, 70y). I find Canderel bitter (MF3, 42y).*

*'Craving' is a cultural thing (all participants generally agreed)*

*I think a lot of our problems come from cultural beliefs, but ever since coming here we have been given lots of advice-for example what to do during pregnancy, heart problems and all that. Lifestyles have changed-we now eat sweets as a treat! (MF5, 70y)*

*The community has cut down on eating 'mithais' (sweets). We now only make them on Eid and festivals (MF3, 42y and MF6, 47y)*

*During Ramadan, I try and avoid fried foods – like kebabs and all that. Fried things are bad. But during Ramadan generally we tend to put on a lot of weight. I've put on a lot of weight because I've learnt how to drive-before I used to walk. (MF3, 42y)*

*Fried foods we know are not a healthy thing but we have always had this as a tradition (MF4, 55y, MF5, 70y and MF6, 47y)*

*Fried foods are a tradition. A tradition especially during Ramadan. I feel I need something like that in the evening-I have had this since I was little. The preparation of all this type of food (samosas, kebabs, sweets and all that) begins 2 weeks before Ramadan and freezers are packed with this (MF1, 30y).*

**Field observation from researchers:** During lunch, a comment was made on the oil content of the food. The oil (as one person commented) was 'necessary in such quantities because it formed 'nice gravy' and made the food far tastier and could be 'scooped up' without the bread getting soggy. Although this goes against the 'normal' convention of appropriate dietary recommendation, this was deemed important for the participants. It is interesting to observe from the findings how South Asians interlinked their views of 'bodily health', environmental influence and 'lifestyle' to their understanding of 'good' health. This can be an important area for community pharmacists to explore when giving advice on public health issues relating to diet and lifestyle, as South Asians may need a different 'approach' to engage them in a more meaningful intervention. Deeper probing of such 'cultural' issues by the researcher highlighted how this could affect medicines adherence.

## **Factors affecting health and medicines adherence**

### ***Weather and stress***

All participants made comments about the weather having an effect on their general health and well being. All participants indicated that being under stress and in stressful situations caused bad health and also contributed to general health and well being. The 'stressful' environment of being in a different country was also mentioned. The effect of heat from the sun was regarded as beneficial for health, especially in facilitating the digestive process. All informants cited what they variously called 'stress', 'worry', 'tension', 'pressure' as responsible for bad health. These English words were often used even by those who did not speak much English.

*I am stressed due to job and lifestyle changes. I never used to go to GP before I came to this country (HF2, 50y)*

*'Bad' health seen less in Africa because of good weather and 'stress and worries'- there are more problems in England because of this. That's why I am on medicines-for blood pressure causes stress (HM2, 50y)*

*We never have had this (knee) problem when we were living back home (Zimbabwe). Is it because of the sunshine? (MF2, 33y)*

*When I'm under stress- I increase the dose of my medicine-I think my breathing gets worse (HF4, 42y)*

*When there is 'tension' in outside countries this causes stress and this affects my health (PM 1, 90y)*

*The weather abroad is better and hence I get better there  
(PF1, 90y)*

*When I come back from abroad can cause stress. I lose my appetite when I return to England. Also I have no bills to pay in India. Family support and environment in India make a lot of difference. (PM3, 63y)*

What was more interesting is the effect of this conversation and findings triggering comments on other factors relating to medicines and medicines adherence. All participants had comments to make about conventional (allopathic) medicines. A variety of responses were obtained, illustrating the diversity of opinions of the participants' experiences of medicine and medicine taking, particularly side effects. It was interesting to note that there were many more comments from the male participants than female participants

*We have to pump in medication' to keep in good health. If we come off the medication-fall into bad health (HM6, 42y)*

*If you take so many drugs this causes 'side effects' then you take a drug for side effect: 'side effect' cycles. This makes matters worse. Too many medicines are bad....though I cannot stop taking them or other problems arise. (PM3, 63y)*

*New drugs and drug trials have a negative effect on health (PM2, 82y)*

*No medicine has ever affected me (PF1: 90 yr)*

*Some medicines are not working- my sleeping tablets do not work but I still take them as I am afraid to stop (HM4, 75y)*

*I am not interested in taking medicines except for my diabetes. We have to take them for diabetes (MF6, 47y).*

Attitudes to medicines in relation to pharmacy and medical service provision were commented on by all focus group participants. Participants from four groups commented that 'cheap' medication was issued, that led to mistrust in the GP and this has an effect on their perception of services. When probed about what participants meant by 'cheap medication', one participant made the following comment, illustrating perhaps a 'misconception' of this issue.

*Doctors prescribe 'cheap' medicines. (HM1, 71y)*

When probed about what they meant and this was translated as 'low category' with 'more side effects'

*GP does not give 'Panadol' (a branded version of paracetamol) which is better-but cheap 'paracetamol'-has side effects. (HM2, 71y)*

*Drs do not prescribe 'expensive medicines'. GPs cannot write them hence I have no trust in my GP. (HM1, 71y)*

*They write 'cheap' medication to save on budget (PF2, 67y).*

*Doctors give low dose, not 'strong medicine' initially. Only when condition gets really bad, a 'good' medicine is given. (PM8, 89y)*

*The Tory government did not allow the GPs to write expensive medicines (PM11, 70y)*

*GPs told to give less expensive medicine and cheaper medicines-how can one get better?' (PF6, 65y)*

*Why then try drugs with us-like drug trials. I had eye problems because of these trials. I had to have an eye operation and ended up having 10-11 different types of medication-I didn't trust all that. (PM2, 82y)*

Participants were given an example of a medicine that could be given once a day being 'better and stronger' than the 'cheaper or 'inferior' option but taken three times a day. The researcher's professional explanation was sought, and an example illustrated of 'a slow release medication' which can be given once a day as opposed to the basic preparation that needs to be given three times a day. Both preparations would have the same desired therapeutic effect, but the 'slow release' preparation may cost more to manufacture and hence the cost to the NHS may be higher. The moderator and researcher observed an acknowledgment of this explanation (researcher's reflexive diary comments).

An interesting comment was made by one Moslem participant about why medicines are prescribed and whether this was necessary

*I do not know whether to trust the GPs medicine-I am not sure especially when they do not go into or check the cause of my problem. They prescribe medicines without a cause (MM9, 39y). (Field observation: many participants in this focus group agreed).*

These experiences and thoughts illustrate that participants were very wary about the political influences on prescribing issues, but what was more interesting is how they linked it to their overall understanding of what they thought of medicines and how this affected their health and well being. Although this data was collected in 2002-3, it was a time when there was a drive to 'rationalise' the prescribing of medicines by local Primary Care Trusts as part of the wider NHS

reforms. Some interesting comments on the sharing of medicines and drug waste were made only by Moslem male participants, but the participants were insistent that this aspect was highlighted in the study. The following is the full excerpt of this conversation.

*When we cannot get an appointment, we tend to use somebody else's medicine because, for certain symptoms, especially minor ones, the medicines have worked for other people (the example cited Ibuleve<sup>(R)</sup> gel for joint pains). What can one do? One has to resort to this. Until we can get an appointment we have to resort to this in an emergency (MM7, 52y).*

***(Interviewer probed-what other medicines?)***

*Panadol (paracetamol) etc-only things for minor ailments. Not GPs strong medicines. (MM7, 52y)*

*GPs tend to write up for too much quantity (MM2, 30y and MM11, 66y). They write up too much medication and many of these medications are thrown away. They should write up for less. If then the patient wants more of the same, the GP should assess them before giving them more.*

***PROBED....WHY?***

*They write more tablets because they do not want you to come back (MM5, 75y).*

*Also because there are no appointments (MM9, 39y)*

*Why write 100 tablets for new drug for a heart problem which last months? We should be having regular check-ups to see whether it is suiting us. It would be a better idea if they write up for less medication so we are forced to go for regular checkups when we run out. (MM3, 31y and MM9, 39y-most participants agreed).*

*When large quantities are prescribed, they are taken like 'chevda' (an Indian snack) or they are not taken at all when even one causes an adverse reaction or have no effect. So they are binned. (MM8, 28y and MM9, 39y)*

Such findings also showed that participants were vigilant of such issues but their interpretation was that of a 'non-caring' environment which heightened confusion and mistrust of health care services. The reliance on GP services and 'trust' is exaggerated in South Asian communities (as seen later) and what is clear is that South Asians 'worry' is heightened because they do not appear to have had adequate explanation about these issues, either by GPs or community pharmacists.



### **Health and health services abroad**

Participants gave a useful insight into how their views on 'good health' and 'bad health' differed when they went abroad. Responses were obtained on this concept from the Punjabi and Hindu participants. All participants commented that felt 'a lot better' when they were abroad in their original country of origin.

*Our health abroad is better because we get better exercise on our farms. (PF 8, 65y)*

*I feel better because of weather abroad. My blood pressure symptoms improve (HF4, 42y) Probed: **how do you know this?** By Self diagnosis: I 'diagnose' my own blood pressure see- 'diagnosed' by self awareness. I also use meters, and my 'symptoms' improve. Then, I just leave off my medicines- no good to take these when you feel better.*

*'My blood pressure changes between countries' (HF6, 45y).*

Comments about GP services abroad were also made by Hindu focus group participants

*The doctor in Rajkot (a town in Gujerat, India) ...he just has to look at me to tell me what is wrong with me. They are that good. I also trust in doctors abroad (HF1, 42y)*

Similar comments were also made when discussing GP services in UK (refer to Theme 2 later in this section). Such beliefs could impact on health seeking behaviour and medicines adherence. Participants from four groups (Hindu male and female, Punjabi male and Moslem female)) commented on how they complied with taking their medicine whilst they were abroad. Six participants in the Hindu female focus group either left off taking their medication, implied that they were not needed, reduced their doses (of medication for long term conditions e.g. blood pressure) or were told by doctors abroad that they could reduce their doses. Hindu male participants also admitted changing their medication regimens.

*Allopathic meds-I do not need these in warm weather (e.g. 'pain killers' for arthritis). 'I came of all my medicines in India and felt no different so I do not know why I am taking all these medicines (HM2, 71y)*

*I have diabetes. I feel better in India and need less medication. I can get away with taking one tablet instead of three (HM3, 66y)*

One Punjabi male respondent made the following comment.

*'For arthritis-Here, steroid injections work better and quicker. In India, arthritis meds made from roots and herbs are better-I leave allopathic medicines I have to swallow and prefer take those instead'. (PM2, 67y)*

Most Moslem female participants comments did not concur with those observed from the participants above.

*We always take our medicines with us. We never leave home without them. When we go to a strange country, it gives me strength and confidence that I have my medicines with me. I will not leave them and I take them how I should. (MF6, 47y)*

The focus group discussions give a more in depth understanding of how South Asians perceive their health and what influences their general health and well being. Many of these observations had not been picked up in the interviews with pharmacists and GPs in Phase 1 (Chapter 5).

### ***Fate (and 'fatalism')***

The Punjabi male and female participants were in agreement about this concept. There were similar comments from male and female participants, who had never been to see a GP or pharmacist. Both these participants were over 75 years of age and 1<sup>st</sup> generation migrants.

*It's our fate-up to God-how long we live for'. This depends on karma and kismet. Whether we take medicines or not, God will decide our fate. (PF7, 84y)*

One Moslem male participant also commented on beliefs in God (Allah)

*I am 66 yrs old and I am very positive about my health. I have age-related problems and sometimes need my medicines. By the grace of Allah I am OK and He will dictate whether I need my medicines. (literal translation-confirmed by back-translation) (MM11, 66y)*

Such observations were only to be expected, as the literature on South Asians and health frequently refers to matters such as 'fate' or 'karma' as an explanation for poor compliance or late presentation. However, it might also be suggested that such statements are 'expected' and produced by community members to demonstrate their piety. Such accounts and statements make clear that illness or emotional disturbances are not passively accepted as being beyond individual control and that each person has a responsibility to look after their health. Lambert and Sevak (1996) make the point that intensity of religious belief may be found in many groups, including 'white' groups. By contrast, responses to a more general question about causes of ill

health produced unprompted reference to a wide range of influences, as seen from the responses above.

The findings from this theme illustrate that health and occurrence of ill health was interpreted in relation to the participants' life situation and in the light of knowledge and social experiences. What is illuminating is how these experiences can be interpreted to shed some light on medicines adherence (or lack of) and how 'open questioning' and probes can be used to clarify this issue. Further exploration of whether this is influenced by 'culture', lack of communication, or the understanding of such issues was explored with South Asian participants in relation to their perceptions of GP and community pharmacy services.

## Theme 2: Perceptions of GPs and GP services

Themes/Categories	Hindu female (HF)	Hindu male (HM)	Punjabi female (PF)	Punjabi male (PM)	Moslem female (MF)	Moslem male (MM)
<b>Theme 2: GP services</b>						
Reasons for consulting GPs	✓	✓	✓	✓	✓	✓
GP appointments	✓	✓	✓	✓	✓	✓
Shortage of GPs	✓	✓			✓	✓
GP receptionists	✓	✓			✓	✓
Confidentiality	✓					
Examination and diagnosis	✓	✓		✓		✓
Feeling Ignored (E.G. CCTV)	✓	✓	✓			
Time for consultation	✓	✓	✓	✓	✓	✓
Improvement in GP services	✓	✓		✓		✓
Race issues		✓				

✓ : means that this was mentioned

### Reasons for consulting GP

All participants commented on general reasons why they consulted GPs. There was a range of answers given by different members from all the groups. Issues mentioned within all groups included cost of medication. The need for 're-assurance' through a 'diagnosis' is discussed later in this section.

*I find the cost of medicines that you can buy ('over the counter drugs') high (HF1, 42y)*

*In one way this country is fantastic. We can get all medicines for free, unlike South Africa and India (HM1, 71y)*

When probed, there were at least two members in every group who said they had never been to a GP.

## **GP appointments and shortage of GPs**

Participants from all groups identified current GP appointment systems to be a barrier to access GPs and GP services. Shortage of GPs was mentioned by some participants mainly from the Hindu and Moslem focus groups. Some participants said that they would visit the pharmacy to overcome making an appointment with the GP due to the lack of appointments.

*I get very stressed due to getting GP appointments so late  
(HF7, 60y)*

*By the time you've got there, you've suffered enough'. (PM3, 63y)*

*(I) will only get an appointment if you say it is an emergency'.  
(PM2, 82y)*

*If I cannot wait for appointment then I have to trust chemist  
(PF3, 76y).*

*I am not happy about the appointment system. If we cannot get an appointment and then symptoms get worse. Then we need an emergency appointment. (MM9, 39y).*

*My wife passed away in Pakistan. When I returned, I had a letter informing me that my wife had been dismissed because she had missed an appointment. It is the doctor who should be dismissed. (MM8, 28y)*

*If appointments are missed-they remove us from their list.  
(MM8, 28y and MM9, 39y)*

*Some of us cannot remember an appointment if it is offered 15 days later-so this is unfair (MM2, 30y and MM9, 39y)*

*If I am not well, I do get to see a doctor the same day-but not my usual doctor. If I need to see my usual GP-the appointment is given for 1-2 weeks. (MM3, 31y)*

*If appointments are offered for 15 days time the (medical) problem disappears and then it tends to be ignored. This could lead to more serious problems later. (MM9, 39y)*

*GPs do not really care. The patient numbers are increasing. Maybe also due to asylum seekers. There is a tremendous shortage of doctors. (MM4, 45y)*

All participants had comments to make about the attitude of GP receptionists hindering access to GP services. Issues raised were about the perception of GP receptionists 'making' a

diagnosis and not communicating in a professional manner. The conversations became quite 'heated' and participants became quite emotional about this aspect. (field observation).

*Receptionists have a bad telephone manner (PM2, 82y)*

*'My medicines supply is blocked by GP receptionists' (HF4, 42y)*

*The receptionists behave as if they are doctors (MM3, 31y).*

*Receptionists are rude and we don't know why. All they say is that 'we are very busy' and we become weary of asking them about anything now (MM5, 75y).*

*Receptionists tell us to take paracetamol-and also ask us what our symptoms are. Then they tell us what is wrong with us! (MF7, 61y)*

*Because of the receptionists I sometimes do not go to the GP (MF1, 30y)*

An excerpt of discussion with the Hindu Male focus group illustrates the emotions and sensitivity of these issues.

***Excerpt from male Hindu focus group discussion re access to GPs due to GP appointments, shortage of GPs and the attitude of GP receptionists***

*The appointment systems ruin our trust. (all agreed). I am an asthmatic. I can hardly get to my GP. When I ring for an appointment if I am bad, I am interrogated by the receptionist and then offered an appointment after 3 weeks. It was an emergency and even then the receptionist said I was making excuses (1). I explained I had no easy access and needed to get taxi. It was very difficult. It made me worse (1). Sometimes the GPs and even the staff respond to us by saying 'go and look for another doctor'-we don't care'-this also affects trust (1,2,3,4,5,8)*

*Drs like to keep patients with minor illnesses and complaints-not the ones with major conditions (3). But can the GP be blamed?-there is an acute shortage of GPs (5).*

*This is otherwise a time-bomb waiting to explode-how long can we go on like this before the situation-this shortage-goes out of control? This needs to be seriously addressed. They 'up there' have no idea how it really affects people at ground level. They keep on saying 'we know there is a shortage and are addressing it' but do they really know how it is affecting people? What you are hearing is just the surface...' (5)*

**The importance of examination, a diagnosis and 'trust'**

Participants from four focus groups commented on the issue of 'diagnosis', re-assurance and 'trust' when asked about their reasons for consulting with GPs. The community pharmacists' training encompasses their ability to screen for a condition mainly through the presentation of

overt symptoms by the client or service user. The consultation with GPs also involves this process, but with GPs this also involves the physical examination of the patient, including the measurement of various parameters and the examination of various body parts for a more definitive diagnosis. The issue of a 'proper examination' was considered to be an important aspect in a 'diagnosis'.

*I trust the GP because he can 'diagnose' ...probed for what she meant..... I go to (the) GP because I cannot measure 'pain' (unlike thermometer) so I have to know. (HF5, 48y)*

*We trust both GPs and pharmacists-however first opinion must be the doctor's (MM1, 28y)*

*I trust only some GPs –not all. (Probed...why and a specific example of Dr B and Dr A was given by the respondent). Dr A physically examined the patient and so I did not trust Dr B, who did not physically examine me. These were doctors in the same practice. (PM4, 53y)*

In addition, comments were also made about the access to clinical records, and in the same conversation, the lack of access by pharmacists to the clinical record was seen to be a barrier. This is discussed later in this chapter.

*The GP knows what we are suffering from-he has our records' (PF3, 76y)*

One respondent illustrated his experience why this was one of the main reasons he would not go to a pharmacist in the first instance

*The chemist does not examine me. He does not have my record of tests and illness. When I felt dizzy a while ago, I went to the GP and he ordered some blood tests. A blood test would assure me of what was really wrong with me. The medicine from the chemist would not be able to affect my proper treatment if there was something shown in my blood test. This would be particularly if I came back from Pakistan and I was deficient in vitamins or had malaria. (MM1, 28y)*

Examples were given by one Hindu and one Punjabi male respondent when they had to resort to the private sector for diagnosis and treatment. The Punjabi respondent gave an account of his wife who was 'misdiagnosed' by the GP and was eventually diagnosed with a terminal illness after a private consultation with a consultant.

*It's too late. The GP would rather change medicines and keep trying others rather than send us to the hospital. (PM11, 70y)*

*I don't think my GP makes the correct diagnosis. If I have to pay money for a 'proper diagnosis' I might as well go to India and have a 'proper diagnosis' (HM3, 66y) Probed to elaborate. In India, we have to pay to see a doctor. Less expensive than seeing a private doctor here-and at the same time we can get a holiday. At least the doctor in India examines us. He can tell what is wrong with the patient just by feeling a 'vein in the wrist'-that good. He is from Rajkot. I trust them in India – better than English doctors. An Indian doctor just 'looks' at you and tells you what is wrong – these doctors are very qualified. Doctors do not even check us or examine us (HM3 and many agreed)*

Patient confidentiality was mentioned by only one respondent in the series; a female Hindu participant who felt very strongly about her medical record and history not being regarded as confidential. She commented on the 'familiarization' of the GP to their patient's own extended family environment could also lead to possible divulgence of the patient's condition to extended family or community members with deleterious effects. This could lead to perceived notions of 'mistrust' in healthcare professionals who are also significant members or have 'leading' roles within a local community, or are in some way related to them. She describes the GP as being friends with other family members and openly discussing her problems with relatives and friends without her permission, which subsequently caused her a great deal of distress and compromised her 'status' in an extended family setting.

*I had quite a few problems and miscarried several times. The GP thought I was 'mental' and told my other family members because he was friendly with them. I was eventually diagnosed with kidney problems by the hospital. I do not trust GPs very easily (HF4, 42y)*

The researcher inquired whether patients went to the pharmacist before going to the GP for minor ailments. Comments were made predominantly by three participants within the male and female Hindu focus groups that they felt 'ignored' when they consulted the GP.

*GPs ignore us if we do not go them first. We have to 'over suffer' until we can see them. **Probed.** We have to be really ill before they see us otherwise they are not bothered. (HF2, 50y)*

*I was given sleeping tablets by my doctor and these medicines are not working. I told this to the GP and the doctor said 'its all in my head'. (HM4, 75y)*

Comments were received from all focus groups about the time given to them during a consultation. The time spent during a consultation was considered important. There were



varying comments made by participants, showing inconsistency in the participants' experiences. There were complaints from two Hindu participants about the use of CCTV cameras at the time of the consultation (CCTV cameras are placed in the waiting areas with the monitor in the consultation room).

*GPs give no time to us (PM5, 71y)*

*My GP has a lot of time to explain things to me' (PF3: 73y)*

*GPs do not have time to check what is wrong with patient –rely on CCTV and always say 'next, next' before patient is finished. They do not even look at patient. (HM4, 75y)*

*In an emergency, they do not spend time with you. For routine appointments, they do spend time with you (MF6, 47y)*

### **Improvement in GP services**

Participants were asked their opinions on how the services could be improved. Comments were received from all the focus groups.

*GP should have patients welfare at heart, not think about budget. Should give medicine that make patients feel better quickly (PM3, 63y)*

*GPs surgery needs more counsellors (for mental health problems) who speak the language – only certain GPs have this service (HF4, 42y)*

*Receptionists need to be better informed about how to 'screen' patients and not act as sole 'gatekeepers'. They (the receptionists) need to be more 'empathetic' (HF3, 41y) researcher note: -confirmed by back- translation).*

*GP should provide more information for minor ailments (HM2, 71y)*

*Prescribing of drugs taken when required ('prn') can be prescribed in larger quantities. **Probed...which ones?** Pain killers like paracetamol. There is no fixed dosing for this and so it is difficult to calculate exact quantities. But regular medication or 'course' medication need fixed smaller quantities. Such drugs (those with precautions) should be prescribed in smaller quantities because of the side effects. (MM4, 45y; MM8, 28y and MM9, 39y)*

*They should have a number system for appointments. Should be offered an appointment within 2 days with a 'number system' where you are given a number to wait to see GP the same session and 3 days for routine appointments. They need to establish a system for 'emergencies'. We should be able to wait to see the GP if it is an emergency. (MM9, 39y)*

The findings from this theme show that despite South Asians relying heavily on GP services, there is clear frustration in their understanding and experiences of this aspect of health service provision. There appears to be an opportunity for community pharmacists to have more 'added value' to this debate, and this was further explored with participants.

### THEME 3: Perceptions of community pharmacists and pharmacy services

Themes/categories	Hindu female (HF)	Hindu male (HM)	Punjabi female (PF)	Punjabi male (PM)	Moslem female (MF)	Moslem male (MM)
<b>Theme 3: Community pharmacists and pharmacy services</b>						
Reasons for consulting	✓	✓	✓		✓	✓
Delivery services	✓			✓	✓	
Pharmacy assistants	✓	✓	✓			✓
Access to pharmacies	✓	✓	✓	✓	✓	✓
Medicines issues prescription and OTC	✓	✓	✓	✓	✓	✓
Professional image and training	✓	✓	✓	✓	✓	✓
'Shopkeeper image'	✓	✓	✓	✓	✓	✓
Race issues			✓	✓		
Improvement in Pharmacy services	✓	✓	✓	✓		
Minor ailments triage	✓	✓	✓	✓	✓	✓
Screening	✓	✓	✓		✓	✓
Medication reviews					✓	
Private consultation areas and confidentiality	✓	✓	✓	✓	✓	✓

✓ : means that this was mentioned

#### Reasons for consulting the pharmacist

Participants were asked the reasons they consulted the community pharmacist. Many participants mentioned that they went to see the pharmacist if they could not get an appointment to see the GP first. Only a few participants mentioned that they went to the pharmacist as their first port of call for advice on minor ailments. Most participants mentioned that they sought the pharmacists' advice on their prescriptions. There was one participant who never went to GP or

pharmacist (elderly Punjabi Female patient). Many participants relied on family members going on their behalf.

*I go for minor ailments to GP first. If I have to wait too long for a GP appointment I then go to pharmacist (HF3, 41y)*

*I only go to the chemist for prescriptions (HM3, 66y)*

*If cannot wait for appointment at the GP I then 'have to trust chemist' (PF5, 70y)*

*The GP has no time to explain anything but pharmacist does. (PF2, 67y).*

*As long as we get our medicine and get better -we like them (PM6, 70y)*

*I would not consult a pharmacist-even for minor things. I need to know what the real problem is. There is no benefit of going to the chemist. They would only give medicine to treat the symptom (MM8, 28y)*

Most female Moslem participants were also complimentary and confident of pharmacists' advice obtained for the management of minor illness for their children. This finding also enhances the notion of 'trust' in community pharmacy services, particularly for children's ailments and medicines. This correlates well to findings obtained in pharmacy studies with the 'white population (Cantrill et al, 1996).

***Excerpt from the Moslem female group (age range 30-70y)***

*I use them to buy things like cough and cold medicines (3). Sometimes we cannot get the GPs appointment for days so we have to resort to the community pharmacist (6). Better to pay money and to get it quickly (3 and 6). With small children, you tend to go to chemist first (1). They are good for advice for children's ailments.*

### **Delivery services**

Participants from three focus groups were complimentary about delivery services that some of the pharmacies in the area provided.

*It is a wonderful service (MF4, 55y)*

Although this is not a 'pharmaceutical' service in its own right, it was interesting to note this finding to the debate of how the 'value' of community pharmacy services are perceived, and that further probing was necessary to further understand what participants understood as a 'professional' service.

### **Pharmacy assistants**

Participants were asked about their perceptions of the 'counter staff' or pharmacy assistants. Comments were received from all focus groups.

*Shop assistants never question me when (OTC) products purchased (PM4, 53y)*

*They give us medicines like sweets' (HM4, 75y)*

*Pharmacists must be more easily approachable-sometimes they are not easy to talk to. I talk to an assistant first-they are keeping distant with their patient (HF6, 45y)*

*They are just 'servers' (HM1, 71y)*

*The counter assistant sometimes gives us advice. (all MM participants in agreement)*

*Lots of people in the front but pharmacist 'at the back'-not sure who to ask (PF5, 70y)*

*Prescription is checked' by 'ladies in front and the pharmacist comes from the back sometimes (PF8, 65y)*

The findings indicate that there is a clear need to promote the role of the counter assistants as the observations seem to negate the 'professional' image that community pharmacy needs to portray.

### **Access to pharmacies**

The concept of 'access' to community pharmacists was interpreted as 'physical' access. All participants mentioned that physical access to pharmacies was good. Access to the pharmacist for 'professional' advice was interpreted in different ways by both the researchers and participants. These are discussed under several categories under themes 3 and 4.

## Medicines Issues (including minor ailments)

The findings have illustrated a unique insight into participants views about the notion of generic medicines (i.e. those medicines that are marketed without their 'branded' identity) being 'cheap' or 'inferior'. On further probing during the interview, it became apparent that this interpretation was confounded by the lack of knowledge of what the term 'generic' meant to South Asians, and how they interpreted 'cheap', and that GPs prescribe 'cheap' medication in order to 'cut on costs'. Contrary comments were also discussed by South Asian participants in relation to 'waste' and that GPs over- prescribed drug quantities. These issues were cited as additional 'barriers' that prevented South Asians trusting pharmacists and GPs. Comments were made by some Punjabi focus group participants on the issue of 'cheap' medication being given to them by pharmacists and that without being offered an explanation, this leads to 'mistrust'.

*I get given 'cheap medicines' **Probed** Cheap generics - when chemist changes brands. This leads to mistrust because chemist says it is 'cheaper'. If I complain enough then the chemist 'concedes'. My medication colour changed and this was not explained and can raise doubts (PM7, 73y)*

*If pharmacists keep on giving us medicines which are different colours every time-how can we trust that they are giving us the right ones? (PF5, 70y)*

*Pharmacist does not give antibiotics-and one can only get better with antibiotics' (PM1, 90y)*

*'If I need an emergency supply of (prescription only) medicine, this is expensive. My pharmacist charged me even though he knew I had them on prescription.' (PF7, 84y)*

When the researcher explained why this had to be done by law the participant admitted to lack of awareness re pharmacy services but also said this can lead to mistrust if no explanation was offered. This participant calmed down when the moderators gave verbal explanation about the process regarding emergency supply of 'prescription only medicines' (POM) (reflexive diary field observation). These findings also add to those relating to participants understanding of 'cheap' medicines being prescribed by GPs (see page 287).

All participants were asked if they knew what the moderators meant by 'minor ailments' and the moderators re-iterated this in the interview. All the participants understood this term when they were given examples of ailments and the term 'minor' was explained using various examples such as simple colds and coughs, general aches and pains. The literal translation of the term 'minor' had to be explained and tactfully interpreted. There is a significant 'reliance' by South

Asians on the general practitioner to assess symptoms and make the first diagnosis and, this seems to overlap considerably with their own knowledge of their condition and their perceived knowledge. The principal investigator acknowledges that such behaviour may not be unique to the South Asian community and this perception must be interpreted in the wider context of medical anthropology (Helman, 1994).

*How does a pharmacist know that 'cough' is not serious without being examined? How can you class this as 'jinni darad' (minor ailment-interpretation in Gujarati). **Researcher explains that pharmacist should ask questions** 'Yes but it's not the same as examining. It might relieve symptoms but what if we need an antibiotic? My father had to go for days coughing and ended up with pneumonia. That's why I prefer to go to the GP first. (HM5, 45y) We are sold the medicine when we just ask for medicine for a cough. If the pharmacist explains that if the cough gets no better we can then go and see the GP. But if they do not tell us then it's better to go to the GP first. I have always relied on my family members for advice and they always say it's better to go to the GP. (HM5, 45y)*

*Sometimes my headache comes on when I am stressed. I know it's due to stress and that is not 'minor'. But I cannot talk to my pharmacist because I don't want him to know I am stressed. I just ask for Panadol<sup>(R)</sup> tablets for my headache and he sells these to me. (PF4, 44y and many agreed with this explanation)*

*I don't think 'pain' is 'minor'. The pharmacist does not take a proper history. **Probed...if they did how would you feel?** If it's done in a more private area, that would be better as I could then 'open up'. But if other people were in the shop, I couldn't do that. I do not like other people to hear what I am saying. The pharmacist does not answer my questions and therefore does not satisfy my needs. That's why I go to my GP (HM2, 71y)*

The community pharmacists' training encompasses their ability to screen for a condition mainly through the presentation of overt symptoms by the client or service user. The consultation with GPs also involves this process, but with GPs this also involves the physical examination of the patient, including the measurement of various parameters and the examination of various body parts for a more definitive diagnosis.

There was significant reliance on the opinions of extended family and community members for 're-assurance' of the need for a referral or self assessment of their condition. South Asian participants were very assertive about the pharmacists' lack of ability to 'diagnose' their problems without an 'examination'. This was cited as an important factor in their endorsement of pharmacists role as a professional in the same way as a general practitioner. Some South

Asian patients do mention the importance of relying on such examinations for a more 'definitive' cause of their problems and their reliance on such facts is paramount.

Participants were also aware that they could purchase medicines over the counter from pharmacies but that this could be a barrier.

*I never go to chemists (for minor ailments) because we have to spend money at the chemists (PM1, 90y)*

*I am aware of pharmacist advice and immediate attention-but I have to buy the medicines. That image is hence that of a 'shopkeeper' image. (HM2, 71y). But 'better to pay than to wait' (HM6, 42y).*

*Why should we have to pay money at the chemist when we can get it free on prescription (PF4, 44y)*

*(I) Do not want to pay for medicines for minor ailments (PF6, 65y)*

*I am aware of supermarkets selling same medicines 'cheap'. I go to chemist for advice and then go and purchase from supermarket because the pharmacy is very expensive. (HF3, 41y)*

Most of the male Moslem group participants were confident about dealing with minor ailments, and about buying medicines

*For minor ailments we tend to sort ourselves out (MM2,3,5,6,7,11 age ranges 30-75)*

*I treat myself for minor ailments. I am not registered here but know what to get from my community pharmacist. (MM4, 45y)*

*Doctors do not give strong medicine. At the pharmacist there is more choice 'tickly cough medicine, chesty cough medicine. Chemists' medicines are sometimes stronger. (MF3, 42y)*

It is interesting to note that the notion of 'cheap' medicines' was also mentioned in relation to 'over the counter' medicines and that the 'interpretation' of medicines being 'inferior' can affect understanding and adherence. This aspect was further probed and participants commented on how this could affect the 'professional' image of the community pharmacist.

### **The community pharmacist's 'professional' image**

All participants commented on their perceptions of the pharmacists' role.



Participants from the Punjabi female group and the Hindu male group commented on this issue.

*A Pharmacist cannot prescribe medicine (PF3, 76y)*

*The pharmacist is 'at the back somewhere and is not 'available' for interaction with me (HM1, 71y).*

*The pharmacist is more interested in (dispensing) prescriptions (HM4, 75y).*

Participants also commented on the issue of 'trust'.

*As for the service-can you trust them? They do not even consult proper books. They consult old books-I saw my pharmacist and noticed the date on the book-it was over a year old! I asked him that and said new books were too expensive. How can you trust them? (HM5, 45y)*

*They rely on locums and assistants and there is no consistency. I prefer 'regular' pharmacist. (HF4, 42y)*

Comments about the 'shopkeeper image were observed in all focus group discussions, but it was interesting to observe that the comments were variable and in many cases peer-led.

*Chemists are money minded. They want to make money. They are just shopkeepers (PM1, 90y)*

*Pharmacists cannot prescribe what doctor can and pharmacist has no authority. He will only sell what is expensive for more profit (PM2, 82y)*

*They are always busy with business. My pharmacist owns 5-6 shops and has no time to speak to you (HF4, 42y).*

*Pharmacists are mainly 'representative led'-they promote what they can buy at a discount (HM4, 75y)*

*They are not 'true' community pharmacists to serve the community. They just want to make a profit (HM2, 71y)*

*'Most chemists good-but try to make you buy more expensive medication- for a bigger profit' (PF3, 76y)*

*Pharmacists will only give us something because he wants to make a sale (PF4, 44y)*

However, there were some participants who had different comments. One Punjabi female participant commented on a negative comment from the group:

*I have never come across a pharmacist who sells things for the sake of making a sale-he will only give you things to get you better' (PF8, 65y)*

It is interesting to note that in the Moslem focus groups, the concept of the 'shopkeeper' image was not apparent.

*I do not think chemists sell medicines for a profit. If there is a cheaper alternative, they will tell us. (MF 6, 47y)*

**An example of a 'conversation' in the Hindu female focus group highlights the need for raising awareness of the pharmacists' advisory role (age range of participants: 41-50y)**

*I use chemist for information this is OK isn't it? A pharmacist's medicine cannot cure. More information and awareness is needed on this. They are not just shopkeepers (4).*

**Probed.**

*But a doctor's medicines cannot cure either (3).*

*But people think this medicine is better. That is why they go to the doctor. (1)*

*But if they know that some of the medicine that a pharmacist can give is the same as a doctor, people will go to the pharmacist provided it is not expensive. The pharmacists' advice is always good. They should not just be making profits, but guide us. (2).*

*We all need to know more about our health and medicines and their advice should be accepted (5). All agreed.*

These findings show that people have had different experiences of pharmacy services. The researchers did not probe further about the reasons behind this, but the findings do suggest a variation. More importantly, participants were cautious about the cost of medicines which could be bought over the counter. The comments about the cost of medicines as a significant issue give more depth to the findings of the study by Partop et al (1986), Rashid, Jagger et al (1996) which illustrated that most South Asians wanted information to be given to them by GPs rather than the pharmacist, and that more effort may be needed to persuade South Asians to self medicate and this could be considered if the cost barrier could be removed. However, further comments also showed that there could be other reasons for not consulting the pharmacist as the 'first port of call'. Participants were probed to comment on how pharmacy services could be improved for them. Comments were received from four focus groups on the professional skills of the pharmacist and how the role of the pharmacist needs to be promoted.

*Pharmacists should not be just shopkeepers-they are only interested in prescriptions and needs to be addressed (HM1, 71y)*

*'Pharmacists must make an effort to improve their services' (HF6, 45y)*

*More pharmacist promotion from GPs is needed (PM8, 89y)*

Members of the Punjabi and Gujarati male focus groups welcomed a campaign for pharmacists as future prescribers, but they showed a high element of doubt about the pharmacists' skills. Punjabi female focus group participants also made an interesting observation, where the younger participant made comments and the more senior participants showed some doubt.

*Pharmacists are like doctors if they can be allowed to prescribe (Punjabi female participants aged 44-70y).*

*Only GPs are trained on medicines and how our bodies work-pharmacists only know about medicines (elderly Punjabi female participant aged 84 and 90y)*

This concept would need to be better promoted, particularly as the government policies advocate further extended services to be delivered through community pharmacies. This was further explored with participants.

### **Extended services from pharmacists (including minor ailment schemes)**

The researcher and moderator asked all focus group participants to comment on the proposals that pharmacists could be taking on 'extended' roles. Examples were asked for by all focus group participants and comments were received on the concept of minor ailments services, screening, and medicine reviews. The concept of a minor ailments service was described to all focus group participants. This service was to be introduced in Eastern Leicester PCT as a pilot scheme in 2003. The researchers had to explain this concept slowly and very clearly. The 'extended' service was proposed to improve access for those patients who need to go to the GP for a prescription for medication that is normally prescribed by GPs but is normally available over the counter from community pharmacies. In the scheme, pharmacists would assess the patients' symptoms for common minor ailments, give advice and if necessary, provide medication for the symptoms. The medication would be free of charge for those patients who do not pay for prescription charges. The scheme was also encouraging people to use the pharmacy as a first port of call hence improving access and raising the profile of the pharmacist as a skilled professional who provides health advice without the need for an appointment with the GP. The responses were generally encouraging and positive, though some participants were sceptical about the value of the scheme. Some participants still questioned the ability of the pharmacist to 'diagnose' their condition. The lack of access to clinical medical records in a pharmacy was also cited as a barrier.

All participants welcomed the scheme to improve access to pharmacists and overcome the appointment system.

*For minor ailments- I will only use service if patient records are available to pharmacist to help confirm diagnosis. 'The doctor is responsible for us. He can diagnose (PM11, 70y)*

*The pharmacists do not have them (medical records). They do not know what is wrong with us (HF4, 42y)*

*Since there are no records at pharmacy, the Pharmacist always has to ring GP. That's why we go to GP first. (PF3, 76y)*

*There will be no need to wait for appointment or prescription' but what is the value other than that? (HM7, 60y)*

*Minor ailments services-would be a good idea-solves appointment system and better access (MF7, 61y)*

*It will work (MM9, 39y). The queues at the GP will be less and appointments will be available a lot quicker (MM all).*

It has been proposed that pharmacists may be able to provide screening services (e.g. cardiovascular screening checks including blood pressure measurements, blood glucose monitoring for diabetes, cholesterol measurements and associated lifestyle advice). This concept had to be clearly explained to the participants and the researcher had to explain that these would be available at the pharmacy. There was some confusion whether this would be the same as what nurses are currently providing in GP surgeries. In general, most participants commented that such services would improve access. This was one area where the researcher and moderator thought the explanations about the screening were very leading and subjective, and it may be that less weight should be placed on these comments.

*Screening is a -good idea as not everybody can afford machines (HF1, 42y)*

*Screening a good idea to 'save time' for GPs (HM7, 60y)*

*This will be less pressure on GPs (MM4, 45y)*

Comments on other extended services (such as medicines reviews) were made only by the female Moslem group participants during a lunch time conversation (reflexive diary comments). All the female participants were very enthusiastic about this, particularly if this was done in a community centre setting.

*It would work. There would be no need for a GPs appointment. The pharmacists' role as a health advisor then would need to be promoted. At the moment they are perceived as businessman and a dispenser of medicines. They should provide these services free-like the doctors. (MF5, 70y).*

These comments also echo the discussions of the Hindu female focus group participants (see above).

### **Layout of pharmacies and private consultation areas**

This aspect was mentioned by most focus group participants. It was observed from the comments that the need for privacy was considered important, particularly where confidentiality of the discussions was paramount (e.g. in discussions of 'sensitive' issues which, in some cases are classed as 'minor' - for example 'thrush' ).

*Improvement is needed in layout of pharmacy (for new services) (HF6, 45y)  
Realistically in an inner city area and premium shortage of space-how can they have extra room? It would be nice in an ideal world (MM11, 66y).*

*Why should this (private consultation room) be for just nurses and GPs? (PF5, 70y)*

*Pharmacies should have private place. There are certain things that we (as elders) cannot discuss in front of other people. Also I would not think it appropriate for any of my children or grandchildren to ask about illnesses in public. (PM1, 90y)*

*I think more privacy is needed – and the pharmacist must be visible. The consultation should not be and not completely behind closed doors (HF4, 42y)*

*I prefer to discuss my problems privately-out of the way of everybody at the back of the shop (MF6, 47y)*

### **Conversation vignette with Hindu female focus group participants on the issue of privacy and confidentiality in service reconfiguration (age range of participants 41-60y)**

*If I have to go to the pharmacy, I would prefer a bit of privacy and not for everybody else to hear everything. That's how rumours spread and this can be very difficult. (3 and most participants agreed). Not all pharmacies have this-you just talk at the counter where anybody can hear. This is why I think all of us do not seek advice especially on personal things. In our community rumours are spread like wildfire. Also it's a question of keeping things private (4).*

#### **Probed to elaborate**

*Privacy and confidentiality must be there. If I know the pharmacist personally, he must be trusted to keep things confidential-he might know common friends and I should be able to trust him not to say anything personal. I would feel 'is it safe to go that person to discuss personal things? What will he think about me if I have a problem? Will his opinion change about me? What will be his views about me?'. This privacy-it must be visible and not completely behind closed doors because that can also raise suspicions. We should be seen but not heard-this would be good. (4)*

## **‘Race’ issues**

It is interesting to note that the notion of ‘race’ was also observed in comments on GP services. An interesting discussion arose whilst discussing GP appointments and the importance of a diagnosis. I decided to class this as a category in its own right, as ‘race’ was also observed to contribute to the underlying notion of trust in the GPs ‘professional’ services.

### **Excerpt from a Hindu male focus group discussion on the differences between ‘white’ and ‘Asian’ GPs (Age range of focus group: 42-71y)**

*The GP would rather change medicines and keep trying others rather than send us to the hospital. I lost my wife about 1 year ago because of this very reason. My Asian GP kept on changing her medicines, and even when we got into hospital a few months later he did not do all the tests. So we went private. We had to pay. The ‘white’ consultant then did tests and said she had cancer and only a few months to live. He said that she should have been referred earlier-it’s now too late. I feel so bitter about this. I feel angry. If it was a white patient they would have sued the (Asian) GP. . (5)*  
*I trust only some GPs –not all. Dr B (my Asian GP) is very good but it took me time and I had to change GPs before I found him. Other GPs, including Asian GPs do not care-they do not check properly. (4)*  
*Even the (white) specialists at the NHS hospital they only check what my GP has asked them- they do not go into the cause of the problem and that is why I had to go private. (5). I agree-many GPs, including Asian GPs do not tell us why they are testing our blood or why they need to do it often. This makes me very anxious (1, 2 and all agreed)*

During the conversations with younger female Punjabi participants after the main interview, the researcher observed some interesting comments about their perceptions of how ‘white’ pharmacists were consulted as opposed to Asian pharmacists. Two female participants preferred to talk to a ‘white’ pharmacist about their medical conditions, particularly coronary heart disease and asthma. The researchers probed for an insight and were informed that they preferred to talk to a ‘white’ pharmacist who were not in their ‘area’ as there was a ‘fear’ of other members of the community knowing about their problems. They also commented that white pharmacists had better ‘knowledge’ on the subject and that Asian pharmacists were too patronising in their approach to more sensitive topics. Whilst definitive interpretations of this issue are not possible, more insights underlying these perceptions were obtained when participant were probed about ‘stigmatised’ conditions (see theme 5 later n this chapter).

The findings in this theme show that is still a clear need for community pharmacists to improve collaboration with GPs and improve their professional image, and useful insights were obtained

as to how and why this was needed. The findings of this PhD study also illustrate that the 'consumerist' perspective of community pharmacy services was still prevalent. Although the barriers identified do not appear to be unique to this population, it is encouraging to note that participants were positive about embracing the proposed ideas if their suggestions were seen to be more 'inclusive' in designing new or extended services. South Asians participants still appeared to perceive community pharmacists as 'shopkeepers' in the first instance and their interaction with GPs needed to be further explored through the discussions with South Asian participants.

## THEME 4: Communication

Themes/Categories	Hindu female (HF)	Hindu male (HM)	Punjabi female (PF)	Punjabi male (PM)	Moslem female (MF)	Moslem male (MM)
<b>Theme 4: Communication</b>						
<b>GP/Pharmacist interaction</b>	✓		✓	✓		✓
<b>Language/interpreter needs</b>	✓	✓	✓	✓	✓	✓
<b>Hospital interpreters</b>		✓	✓			
<b>Leaflets (as communication)</b>		✓		✓		✓
<b>Counselling on medicines</b>	✓	✓	✓	✓	✓	✓
<b>Improvement in communication</b>	✓	✓				✓

✓ : means that this was mentioned

### GP/Pharmacist interaction

All focus group participants said that communicating effectively with pharmacists and GPs was important.

*GP/Pharmacist communication only good together for prescribed drugs when they can ring the GP (HF3, 41y)*

An example was given by one male Punjabi participant of a good relationship between GP, chemist and patient, but another member of the group had the opposite experience. Raising awareness and knowledge of the prevention of malaria was welcomed by pharmacists and South Asian participants. Barriers relating to this subject included the perception of 'immunity' against malaria by participants, and the notion that if they had already had malaria, they would be immune to subsequent episodes.

*It's a vicious circle-GP surgery says go to pharmacy-pharmacy refers back to GP-leads to confusion and mixed messages. We travel back 'home' (country of origin) but we are told to buy malaria medicines. We are told by our GPs to go and buy this from the chemist, but this can be very expensive. I am told I am not immune to malaria. The chemist says different things to the GP and the nurse. If we knew a little more about this*



*it would definitely help. Then it would be our choice whether to buy or not. But to be told we must buy it without a good explanation. (PM9, 66y)*

Interprofessional collaboration and communication was also an area that was explored with GPs and pharmacists in Phase 1 (Chapter 5) and has been highlighted in the literature. It was particularly interesting to note the findings in relation to counselling and health promotion.

### **Counselling on medicines, general health and lifestyles**

When probed by the moderators, no participants admitted that they had been actively referred to the pharmacist by their GPs for advice on any health issues (e.g. health promotion) or active counselling on their medicines. When probed if GPs counsel on medicines they prescribed, many participants were quite vociferous about this issue. These comments also relate to the observations relative to medicines adherence in the previous themes.

*GPs do not tell us why they are testing our blood or why they need to do it often. This makes me very anxious' (PM6, 70y)*

*'When I get anxious or feel unwell, I take some sugar mixed with natural yoghurt and I feel better. I am on insulin and I adjust my own dose according to my blood test at home and my own personal experience. All the doctor has told me is that I have to have the insulin but nothing about the dosing instructions or any adjustment (PM7, 73y)*

*GP never explains how to take medicines-only chemist explains, even though the GP speaks my language (PF2, 67y)*

*GPs never tell us about side effects or anything. We rely on the additional labels regarding precautions put on by the pharmacist (MM4, 45y)*

*GPs do not tend to refer us to our community pharmacists for advice on our medicines-they just tell us 'get this from your chemist'. (MM2, 30y)*

All Hindu female participants were aware that they could get advice on medicines from community pharmacists, and that it was 'good advice' when they got it. Two male Hindu participants commented that they were given no counselling and no explanations provided by 'anybody in the shop'. All participants commented that most of the time, pharmacists did not give advice or counselling on their medication unless pro-actively asked.

*Sometimes instructions are 'guessed'. I am only counselled if you ask them (HM4, 75y)*

*I rely on family to interpret and translate my dosage instructions. I need more assurance. (HM3, 66y)*

*No questions asked by regular pharmacists either.(re OTC purchases or interactions, side effects of POMs) They know what medicines we take-it is on their computer' (PM11, 70y).*

*Pharmacist advice good only when I ask them for this (PF5, 70y)*

*I do not actively seek the pharmacist's advice except when I go and collect my prescription. I ask about side effects. The chemist does not give advice unless I ask for it. (MM9, 39y).*

*Our chemist is very good. But he only gives advice when we ask for it (MM8, 28y)*

*Chemists do not refuse advice but we have to ask them. (MM all)*

A comment was made by a male Moslem participant in response, alluding to a 'variation' to the debate about counselling and how this could be interpreted by the patient if a fuller explanation was not given by either the GP or the pharmacist.

*The chemist also tells us not to take medicines prescribed by the GP (MM6, 48y) **Probed.** My son suffered from dizziness. My GP gave my son medicine and said 'this will keep you calm'. He (the GP) did not go into the cause of the dizzy spells or ask why. The chemist then said to me that if we were not told the causes then we should not take the medicine-there was no need. **Probed...so what did you do?** We didn't know what to do. I was so confused. We decided that my son may not need to take it and that if anything happened we would just call out the emergency doctor. **Probed: did you need to?** No-but we were feeling a little angry. The pharmacist could have calmed us down, but he was really busy and I did not want to ask him anymore.*

When participants were probed if they sought the community pharmacists advice on issues such as general health and lifestyles, most admitted that they did not get any active advice on these matters unless they pro-actively asked for it. Many found no need to go to the chemist for advice on health (general observation from all focus group conversations)

*Chemists are always very busy. (MF 5, 70y and MF6, 47y). I have never been given advice about food or exercise.*

All participants were asked how communication could be improved, and the suggestion of better 'consultations' was suggested.

*GPs and pharmacists should spend more time with their patients. It's not just about whether we understand instructions. **Probed to elaborate.** If they spent more time with us, I can then tell them how I really feel. Sometimes it's also the tone of voice. (HF2, 50y)*

*We need better communication between pharmacist and GP. We can have peace of mind as we can be assured that what the pharmacist tells us is 'under supervision' of the doctor'. (HF3, 41y)*

*Information and access to medical records from Doctors should be available hence better communication needed. This will save time (HF2, 50y)*

*The Government needs to be more pro-active about improvement in services but the public also need to be consulted (HM1, 71y)*

*Chemists should ask more pro-active questions about medication and health. They should know how to consult – like a doctor. But they do not even ask me about my general health. (HM2, 71y).*

*There should be somebody between the pharmacist and the shop assistant-somebody like a dedicated person for liaison' with the pharmacist if the pharmacist is too busy. They must have knowledge of how to speak with us. (MF5, 70y)*

### **Communication in different language/interpreter needs (including use of patient information leaflets relating to medicines)**

Punjabi participants had more communication problems as many did not read or write own language and relied on verbal communication. They all admitted that formal translation was not a problem as they could 'get by' by talking verbally with pharmacist and/or the GP who could speak a similar language to Punjabi (mainly Hindi). The Gujarati speaking focus group participants also reported having no language communication problems. All participants had access to GPs and pharmacists that could speak or understand their language. Most participants accessed GPs who spoke their own language or went with family/friends. Nobody had been told of or had any experience of translation services

*We have no need for interpreters- we take family members with us. If it is private I will take my daughter with me-not anybody else. I trust my daughter. (PF3, 76y)*

*Our family members and friends interpret if we cannot get by (all Moslem male participants). They normally accompany us.*

*At the GPs we take family members or they call in the receptionist to interpret (all MM participants)*

When participants were asked to elaborate about dosage directions on medication labels, many participants commented that pharmacists offered to write dosage instructions in the preferred language or verbally explained the dosage instructions (either personally, or by a friend or via a member of the pharmacy staff).

*My chemist explains or writes in Gujarati. (HF3, 41y)*

*Our main problem is for those who speak Kachhi (a colloquial form of Gujarati). Kacchi is a spoken language only-not written. So this is a problem. (MM2, 30y)*

*If I don't understand, I will get friends to write on the labels for me (MF5, 70y and MF7, 61y).*

Three female Moslem participants illustrated significant issues on access to interpreter services and the 'knock-on effect this had on their perception of the health services.

*My husband only speaks Gujarati. He went to what he knew to be a Gujarati speaking GP-he has seen this GP speak in Gujarati in the community. When my husband went to see him, he refused to treat him and was told to speak in English. He was being funny and was forcing us to speak in a language we could not. My husband was confused and cross. We had to change surgeries. At the new doctor, we had to tell them at reception that we could not speak English. They said they had to arrange for an interpreter and this delayed them giving us an appointment for 3 weeks later. That was the only time an interpreter could come. So we had to change surgeries again. This has happened to several of us (MF 5, 6 and 7 ages 47-70y).*

One Hindu male participant and one Punjabi male participant commented on issues with the availability of interpreters in the hospitals

*The hospital has no access to interpreters. (I was) made to wait for hours-got a 'telephone receptionist' to interpret-depends on chance (PM10, 80y)*

*I had to rely on Gujarati-speaking ward cleaners for interpretation (HM4, 75y)*

In the Punjabi Male focus group, many participants could not read or write their own language. They all commented that Patient Information Leaflets (PILs and package inserts) are only useful for those who can read and as such were of no use to them. One Hindu male participant also admitted that leaflets were off putting and alarming if he just read them and that the pharmacist

needed to give more time to explain the content of the leaflet. The findings from the community pharmacist interviews show that there was very limited counselling using package inserts and that counselling was done on an 'ad-hoc' basis, particularly with participants whose first language was not English. The apparent lack of use (and availability) of suitable interpreters and the reluctance by South Asians to use interpreters can be problematic. This has been also highlighted in the literature (Chapter 3) and the findings illustrate that communication problems are still prevalent.

### Theme 5: Cultural beliefs

Themes/categories	Hindu female (HF)	Hindu male (HM)	Punjabi female (PF)	Punjabi male (PM)	Moslem female (MF)	Moslem male (MM)
<b>Theme 5: CULTURAL BELIEFS</b>						
<b>Comp/alternative meds</b>	✓	✓	✓	✓	✓	✓
<b>Paan</b>						✓
<b>Alternative practitioners</b>	✓	✓		✓	✓	✓
<b>Religion and fasting</b>	✓	✓				
<b>Ramadan</b>					✓	✓
<b>Male/female issues</b>	✓	✓		✓	✓	✓
<b>Mental health/stigmatized illness</b>	✓	✓				✓

✓ : means that this was mentioned

All focus group participants were asked for their opinions about their cultural beliefs and how this impacted on their health and health seeking behaviour and medicines adherence.

### Complementary / Alternative remedies

Varying views were obtained on the use of alternative medicines and whether they were used as a true 'alternative' to allopathic medication or used to complement allopathic medication. Participants found it difficult to distinguish between alternative and complementary therapies per se, and also included 'home' remedies, homeopathic medicines or herbal remedies in their discussions. The researcher could not tell whether they understood the differences between the terms.

*We have to resort to use this because we do not get a GP appointment. What can we do? (MM2, 30y)*

Most participants tend to use 'home made' therapies alongside allopathic medication. Issues arose about the side effects of allopathic medication and that 'alternative' medicines do not have side effects.

*We trust the more 'simple' remedies' (HF5, 48y)*

*My children are better at this than I am. (HF 2, 50y and HF3, 41y). If I fall ill, my children make us these home remedies with ginger and turmeric and all that and ask me to take it. They are very 'with it'. (HF 3, 41y)*

*There is no need to go to GP often if use 'home' remedies (HF 6, 45y):  
**probed:** honey and lemon and turmeric mixed at home for a sore throat*

*Home made medicines and herbal medicines have no side effects, but the GPs medicine (Allopathic) is better but these have side effects. (PM7, 73y)*

*Home made medicines take a longer time to have effect. Allopathic medicines work quicker.(PM8, 89y)*

*I do not know whether they are successful. I think they are useful for minor illnesses but only research will tell (HM3, 66y)*

*These alternative medicines do not work in England (PM10, 80y). **Probed** For my arthritis-here, steroid injections work better and quicker. In India, arthritis medicines are made from roots and herbs and are better-I leave allopathic medicines here and I swallow and take those instead.*

*We 'make medicines at home', but still end up going to GP (PF3, 76y)*

*I believe very much in home remedies. Especially with babies. They do work (MF1, 30y)*

*Herbal medicines are very slow acting. They do not work as fast as Panadol®. This makes a difference. But in the long term they are very beneficial . We use these herbal drugs and homeopathic medicines as 'desperate' measures to get rid of pain! The vulnerable people take them. They try them instead of allopathic medicines or in situations where allopathic medicines do not work. They are not used as first choice as we do not get instant relief from this. (MM9, 39y)*

Participants were asked whether they 'volunteered' information about the use of alternative or home remedies to the GPs during a consultation or when they went to the pharmacist for their medication of health needs. All participants said they did not volunteer this information. One Punjabi female admitted why.

*If I tried these first and then went to GP, the GP does not give me time. Hence I do not volunteer info re use of alternative medicines readily. (PF6, 65y)*

Comments were also made on the use of herbal and particularly 'ayurvedic' medicines and they were mainly used by participants that went abroad.

*Ayurvedic medicines do not work here because of the weather. They do not work in cold weather (HM1, 71y)*

*Alternative medicines in India better for diabetes (HM2, 71y)*

*Ayurvedic, herbal and homeopathic medicines do not have detrimental effects do they? No matter how many you use. They are better than allopathic medicines. (Probe: do you use them and where did you obtain them from?) I got them from India. I got them from Ayurvedic practitioners. The advice and the quality of medicines depends on how much money you want to spend – in 'annas' (compared to pennies in GB) or 'rupees' (compared to pounds in GB) (MM10, 54y)*

The findings illustrate the need for a 'three-way' 'communication between community pharmacists (or GPs), the traditional practitioner and the patient. This could lead to a more meaningful intervention as outright antagonism against alternative and complementary therapies could be counter-productive.

### **Consultations with alternative practitioners**

All participants were asked whether they knew of alternative practitioners such as hakims (mainly from Pakistan) or Vahids (mainly from India) or any other types of alternative practitioners. None of the participants from the Punjabi focus groups used alternative practitioners. Other participants were also probed if they consulted such practitioners and the reasons for this.

The responses were varied.

*I do not like vahids. I think the vahids knowledge relating to their medicines limited. I will only use the vahid if I have a little knowledge about their medicines (HF 1, 42y and HF3, 41y). **Field observation: many Hindu female participants did at some point consult a vahid either here or abroad.***

*Vahids do tell us not to 'stop' allopathic medicines but can 'cut down' on them. The vahid I consulted told me to stop all allopathic medicine completely and my little girl's asthma got a lot better over time. She is now 9 and has not had a problem (HF 3, 41y).*

Moslem participants commented on Hakims and Vahids, as well as 'other' practitioners.

*I consult herbalists advertised on MATV (MF4, 55y). I have found their advice OK.*



*They (alternative practitioners) have got qualifications and I think have got medical degree or qualification. They have to be competent. They check me thoroughly. They check you all over, but they can tell just by feeling a blood vessel (a vein) what is wrong with you. They also advise on diet – not to eat sour and hot things (because of my GI problems) and what diet is good for me. I do trust them. They can diagnose (MM3, 31y)*

*Hakims medicines are very good. I always consult them in Pakistan. His medicine always cures my mouth ulcers. (MM5, 75y )*

*Some people do travel to India or Pakistan and see alternative doctors to get their 'incurable' diseases seen to- for example. allergies and eczema. This is when GPs medicine does not work. And in some cases the Hakim's treatment has worked. (MM6, 48y)*

Even if GPs and community pharmacists were to judge the alternative treatments as ineffective, but not in themselves harmful, it would still be important to explore this in a consultation, and an opportunity for the community pharmacists to do this as a way of improving the practitioner-patient relationship.

What was commented on by the Hindu and Punjabi focus groups was the influence of religious gathering and messages that some of the 'leaders' or 'gurus' preached on the large gatherings that are prevalent in these communities. The influence of 'alternative' practitioners visiting the UK and the interpretations of the messages such practitioners can give in relation to medicines adherence should not be underestimated.

*I felt a lot better after listening to Yogic xxxxx sermons. He said that I may not need to take all these 'heavy' medicines for my blood pressure. By relaxing, doing yoga and having faith in what he says I feel that I am normal. I do not have to take my blood pressure medicines. (HF3, 41y).*

### **Paan, kohl and betel nut**

All participants were asked about their use of paan, kohl and betel nut. Participants from the Punjabi group did not have any comments and the Hindu focus group participants knew about these substances and that they were harmful. Most participants resorted to using this 'socially'. The following quote from a Moslem female participant highlights her 'addiction' to this substance, which led to an interesting debate between the rest of the participants. What was particularly interesting was their candid discussions about the consumption of 'paan' in a recreational context, but the engagement of community members and the researchers in

understanding how they perceive their knowledge of 'paan' and its potential detrimental effect on health. The implications of the product causing 'cancer' was 'shared' amongst community members in a more sensitive manner through education and debate in a community setting.

*My paan is my life and soul! I have had a 'stomach' problem since I was young whilst living in Africa. I could not tolerate food. No doctor's medicines helped. A friend told me to eat paan with a bit of 'tamaku' in it. It helped me. That is how I got on to eating paan. I know it is an addiction and I am addicted to it. But, it is for my health. It stimulated hunger and digestion. I could tolerate food and nutrients. It has now been 35 years since I have been on Paan. Now the GP is telling me to leave the 'tamaku' because it is bad for me. I know this-but I cannot leave it completely. I need paan while I am sitting down and resting and with nothing to do. What can I do? I am addicted to it! (5)*

*My husband has bladder cancer. The GP said it could have been due to the paan he always used to eat. He is much better now that he is treated and has stopped eating it. (6). But you can get cancer without eating paan (4). The hakim did not tell you to stop eating paan so there cannot be anything wrong with that (1). But you really should stop-look at my husband-he's better (6). Its best to discuss it like this and have somebody here to talk about this isn't it? (6 and 7). I will come and ask if there is an expert who can tell me what will happen but it's good to do it as a gathering with friends-we can all learn (4). But they cannot force us to stop it can they? (5). But we can all help you (all participants).*

**Age range of Moslem female participants: 30-70)**

No comments were obtained for using kohl except for cosmetic purposes, and no participants were aware of any significant harmful effects of betel nut (areca nut) apart from its use as a digestive 'stimulant' (all participants) or as a religious offering, particularly in the Hindu community.

*We use 'supari' (betel nut) in many ways. In its 'raw' form we use it 'whole' as an offering in the temple. It is considered holy and pure. 'Supari' is used to complement 'paan' –it is shredded and can be flavoured. It can also be eaten after a meal shredded-on it's own. It aids digestion. (all male Hindu participants agreed)). I do not think it does harm. It's the red 'tamaku' (tobacco?) that I think is dangerous, but I really don't know. (HM4, 74y)*

## Religion and Fasting

Participants were asked to comment on how they perceived 'fasting' and if this was a religious or cultural issue. They were also probed on how this impacted on their health and well being, and how this affected medicines adherence. The Punjabi focus groups did not have any comments on this topic. A Hindu female participant believed in Jainism (an aspect of the Hindu culture). A certain times of the year, she abstains from taking medicines during the hours of a fast. She commented that this was her personal belief. The other female participants pointed out that there were no 'restriction' in the Hindu religion, but personal beliefs and strong family influences played a large part in this community. One female participant commented that the GP advised her to continue medication during a fasting period because she explained the reasons for continuing the medication. Researcher observations post interview noted that all participants said that 'fasting' is not a total abstinence from food during the day. Some faiths 'allowed' the consumption of fruit and drink and certain types of food that were not prepared from flour or cooked in a certain way. The male Hindu participants admitted that fasting was more of a 'female' issue and that they (ladies) believed this to be part of their religion

*We cannot expect our religion to cater for medicine taking  
(HM4, 75y)*

*Health must be put before religion (HM1, 71y and all participants agreed)*

*Many ladies fast 'but still eat chips'. They believe more in religion. (HM2, 71y)*

When probed if participants mentioned the issues on fasting to their GPs, one male Hindu participant said

*We do not tell GPs about these issues. Doctors cannot force people not to fast. (HM5, 45y)*

The fast of Ramadan was discussed at length in both the Moslem male and female focus groups. Most of the diabetics in the room fasted. They were not insulin dependent and could 'get by' on shorter days. They admitted there was a problem on the longer days.

*We fast from dawn to sunset. These days the days are very short. Main problems arise in the summer (MM 4, 45y)*

*From dawn to sunset we do not eat or drink anything-not even water. (MF1, 30y)*

*Religiously, if you are on medication, you are allowed to abstain from fasting. One gets permission to be excused for this (MM 9, 39y)*

*This Ramadan I was lucky-I did not suffer as much as usual. A lot of diabetics-they are not able to fast. I have been able to manage. If the days are short-we can manage. On longer days we as diabetics have problems. In summer dawn is before 4am and at night about 10pm. So I become 'all shaking', sweaty and my lips go white. But I know I cannot give up the fast. This is our belief. I must carry on until I can. It is my worship to Allah! We have to do it! On shorter days-it is a relief! If you cannot fast-you can be absolved if you give money for good causes. (MF1, 30y).*

The moderator probed to explore the following issues. Do they ask their GP about what they should do during Ramadan? Do patients pro-actively ask GP about whether they should abstain? If GP advises they will listen? Most participants do not ask their GP and the groups discussed this amongst themselves.

The manager of the community centre (male participant 9) explained this on behalf of the male group, who all agreed with his explanation. Comments from the female focus group also concurred with this account.

**From the manager of the community centre Moslem male focus group (participant 9)**

*For diabetics-they are allowed to abstain. If a person is going to be harmed or disadvantaged if they fast, then they do not have to. They do not have to fast at all. If a person is on a course of medication (15 day course or something), they can abstain from fasting during that period and then rejoin the fast. Their rewards may not be that high. Some people fast outside the fasting period also. The key thing is that the person should not come to any harm or detriment to their health as a consequence of fasting. This abstaining from the fast only applies to 'dangerous' conditions – not to minor ailments. 'Dangerous' conditions are those for which you have to take regular medication. These conditions normally are dependent on what the doctors say-the doctor's diagnosis and explanation is respected. This is critical. This is also respected by most mosques. There is no need to ask the priest. One should rely on one's own judgement with the doctors' advice. The 'mullas' and 'imams' (priests) do normally remind their congregations of this guidance of who can abstain. This is outlines well before the month of Ramadan and also on the timetables of the fasting period. The Health Authority should be aware of this.*

When probed if they communicated with pharmacists about Ramadan participants said they did not discuss this issue with them. What the findings strongly illustrate is the importance of engaging with community members and leaders, priests and clergy to understand these

concepts and how to apply them in working practice in a more meaningful and 'responsive' manner.

### **Male/female issues**

The Punjabi focus female participants did not comment on this issue even when asked. They were a very subservient group and the interviewer found this issue difficult to discuss, even though she was from the same cultural background.

Participants from four focus groups confirmed that this was not a 'cultural' phenomenon. Some participants indicated that who they consulted (male or female health care professional) depended on what the problem was. They consulted health care professionals that could 'deal with their problem and depended on how 'sensitive' the problem was. No participant would tell the researchers exactly what they meant by 'sensitive', even though the groups were gender segregated.

*I use female nurse at surgery for very sensitive issues. I will not consult male pharmacist about this (HF2, 50y). **Reflexive diary entry:** Participant only divulged these issues in private after the focus group. Symptoms included pain on intercourse and thrush, as well as wheezing as participant was asthmatic.*

*Consulting GPs of the opposite sex is not a problem-because of 'professional' status (HM4, 75y)*

*Also have a choice - don't have to speak to female pharmacist-but no option but to speak to the GP (male or female) (HM5, 45y)*

*I would look around for male professionals preferably to discuss problems (PM 2, 82y PM3, 63y and many others in agreement). Even in a shop. It's not a problem with the younger generation as it is with the older generation.*

The Moslem male group generally was not fussed about seeing GPs of either sex. There was not a problem with pharmacists either provided they trusted the pharmacist or the pharmacist provided a good service and spoke to them with respect. The group said that the gender issue is a problem with females and that they should have more lady doctors. Privacy in a community pharmacy was also an important issue for female participants.

**Moslem female group discussion on interaction with male health care professionals (age range 30-70)**

*For some (sensitive) things I can only talk to a lady (nurse or GP) but otherwise I do not mind consulting male health professionals.*

*(6)*

*I do not mind seeing a male GP because it is private-I would not like to talk to a male pharmacist unless there was some privacy (3). Also we know our GPs for years and years and hence we trust the male GP. My GP respects our modesty and advises that a female is present when he needs to do a sensitive examination. He also explains the reason for examining us. This is good (3 and all agreed this to be a good practice.)*

**Mental Health and stigmatised problems**

This area was explored with all focus group participants. The Punjabi focus group participants were very reluctant to discuss these issues and could not be drawn to discuss this issue. Participants from other focus groups had to be probed on this issue. Generally, participants were reluctant to discuss mental health issues or those associated with 'stigmas' with pharmacists and also with GPs. With pharmacists, issues were raised about confidentiality and privacy. With GPs, the time factor was an issue with many Hindu participants.

*I cannot discuss with doctor as Dr does not have the time to discuss these issues (**Probed...what issues in particular?** You know, 'ladies' problems, marriage problems.... (**could not elaborate but assumed that researchers, who were both female, understood**). It's nothing something we readily discuss anyway because we sort it out among our close family and our own community leaders in private. (HM4, 75y)*

*I would discuss stigmatised (mental health) conditions if privacy was there in a pharmacy. (HF4, 42y )*

*'A discussion with the joint family would be preferred in some cases, but not in others (HF3, 41y). There are many problems-even in joint family about privacy and confidentiality. (many participants)*

*'GPs look at their CC TV cameras. If there are patients waiting, they do not want to discuss 'other' problems and many times it is difficult problems and I sometimes need time to explain. (HF3, 41y) (This was also mentioned in the Theme 2).*

When probed about how they would like services for mental health problems to improve, the Hindu female participants had a suggestion.

*GPs surgery needs more counsellors who speak the language – only certain GPs have this service (HF3, 41y and HF7, 60y).*

*This (not talking about stigmatised problems and mental health) is a very 'Asian' thing. Generally we are not afraid to speak about this to the GP but what if somebody finds out and it spreads to the community. We are then regarded by our own community as 'different' and that is not good for us. (MM4, 55y).*

*A lot of the time we do not know what depression is let alone admit it. We do not know whether it can be treated. In our community it is not interpreted well or in a positive way. It affects marriage and work prospects. (MM9, 39y)*

Valuable insights were obtained from local Moslem community leaders illustrating examples of services that could be delivered in a 'sensitive' and culturally appropriate manner, such as how 'stigmatised' and 'sensitive' issues are viewed by this population. Moslem South Asian service users commented that there are social and cultural 'stigmas' associated with certain 'stigmatised' conditions and that could have social consequences particularly for young female service users as this could affect their 'marriage' prospects and status within the family and wider community. The participants in the male Moslem focus group were not willing to discuss their feelings directly with the moderator until the end of the explanation offered by one Moslem participant (no 4, 45y).

*Marriage can be a huge problem in the community. We hide these things from our GPs. Confidentiality is the reason for this. 'Mental illness', asthma, disability is badly interpreted in our community – for example she is 'mad' and she can be 'labelled'. Hence we do not talk about this. Even if one of the parents suffers from a mental illness or epilepsy or asthma the chances of their offspring or siblings getting married within the community are very small. Hence it is very 'taboo' and not discussed. These are all personal problems. How can a doctor solve them anyway? Nobody can help so we have to solve it between family members or by ourselves. We can't even be seen using 'pumps' when we go visiting friends.*

Views about this were not sought from female participants on this topic due to lack of time, but it was casually discussed over lunch. Their comments mirrored those of the male Moslem group. The findings from this theme illustrate a valuable insight into these issues, and, together with the findings from the GP and pharmacist interviews, a picture emerges to understand some of the areas that could explain non-adherence to medicines or some of the deviances to medicines adherence reported in the literature as well as the need for better education and training of

health care professionals on these issues and the need for more exploring more appropriate ways of engaging with this community in aspects of health education and health promotion.



## Theme 6: Education, information and health promotion methods

Themes/categories	Hindu female (HF)	Hindu male (HM)	Punjabi female (PF)	Punjabi male (PM)	Moslem female (MF)	Moslem male (MM)
<b>Theme 6: Education, information and health promotion</b>						
<b>Knowledge of pharmacists training</b>	✓	✓	✓	✓	✓	✓
<b>Health promotion methods</b> Leaflets Video, media and newspapers Peer education	✓	✓	✓	✓	✓	✓
<b>NHS Direct</b>	✓	✓	✓	✓	✓	✓
<b>Other tel. Help lines</b>	✓		✓			✓
<b>Computer use/IT skills</b>	✓	✓	✓	✓	✓	✓
<b>Information on health issues: Other ideas</b>	✓				✓	

✓ : means that this was mentioned

### Knowledge of pharmacists training

Most participants said they lacked information about pharmacy services and were not educated about the role of the pharmacist. None of the participants had received verbal explanations and all relied on passive information through contacts. Two Moslem participants knew that pharmacists undertook a degree course, but this information was obtained through contacts and relatives who were pharmacists. When probed, the Hindu female participants said that they were aware of the pharmacists being a 'dispenser' of medicines but were not aware that pharmacists had also been trained as 'health advisers'. All the participants asked for some information about this and were very receptive when the moderator and researcher volunteered this information to the groups. The groups also welcomed the idea of community pharmacists as educators, particularly from the researchers' experiences of visiting the community centre and holding the focus groups within these settings.

## Health promotion methods

Preferred methods for health promotion and health advice were explored with all focus group participants. A variety of responses was obtained from all participants.

There were mixed responses about the availability and the use of translated leaflets, with many participants admitting that they did not notice them and did not read them. Most participants preferred verbal explanations. The content of the leaflets was a cause for concern to some participants. Each focus group had participants that could not read or write and were not educated, particularly the elderly participants.

Most participants also said that leaflets were available for passive uptake and not actively promoted.

*There are too many advertised leaflets and I do not trust them (HF3, 41y)*

*I pick up a leaflet only if I am interested (in the topic) (HM6, 42y)*

*If you rely on the information in a leaflet, this puts you off taking medicines as there is no explanation about anything relevant (HM5, 45y)*

*There are irrelevant leaflets for example on family planning. I see nothing else and hence I do not tend to take notice (elderly Punjabi female patients)*

*Gujerati leaflets are picked up but more should be openly available. They are not seen as much as the English leaflets. I do not read Gujarati but I get my family members to read it for me (MM5, 75y).*

*I think Gujarati leaflets are a waste of money. They are no longer needed. Many years ago - yes – we did not understand English. But now-everybody can speak some English - they have learnt it or have family members who can speak English. A lot of important leaflets are available in all the languages (MM9, 39y).*

*I agree, leaflets create a mess and are used as junk mail and are binned. People will only read leaflets on a 'need to know' basis (MM4, 45y -all participants agreed).*

*Some leaflets are just picked up and binned-there is no interest in them. Look at all the leaflets we have here in the community centre. Who reads them? Until it is of interest-nobody bothers! (MF5, 70y)*

All participants were asked about the use of media and videos for health promotion. Comments from most participants were received. Many agreed that this was a better medium for health promotion than leaflets.

*I relate better to video as the explanations are better. For example, I saw a video of asthma for schoolchildren in a 'school' setting and this was really good. Also 'breastfeeding' in Bengali community centre which I thought was really good (HF1, 42y).*

Many Hindu and Punjabi male participants did not listen to the radio and were very negative about health messages on the radio. They preferred newspapers, particularly newspapers available in their language. Most participants agreed that television was a powerful medium to get health messages across.

*People tend to watch their 'favourite' programmes-hence a suitable method (e.g. short bursts in between favourites) needs to be considered (MM3, 31y and MM5, 75y)*

*I always watch programmes on health promotion. I gain knowledge on this. It helps me to know about new research. (MF3, 42y)*

*MATV is worth it as most of our people watch it. It reaches everybody (all MF participants agreed)*

An interesting comment from a female Moslem participant illustrated the concept of 'denial' when health issues were discussed on television.

*Sometimes, you do not want to listen to the truth! I love my food-my achaar (pickle) and all that. And when you are told you have to stop them because they would aggravate my headaches and all that-I do not like it. If I eat, I must enjoy my food. So when this comes on TV (i.e. advice on diet) I do my disappearing act. I suppose there must be more like me (MF4, 55y).*

Participants from all groups commented that peer education on health and health related activities was generally well received in a community setting. They enjoyed face to face interaction. Some participants commented that the will to go to such programmes was there but that finding the time to go to such events could be a barrier. Examples of health promotion activities at larger events where there were 'other' communal activities would also be beneficial (such as a 'Mela': see glossary). Participants had not heard of specific health related initiatives (for example 'Project Dil: see glossary) and these needed to be more publicised.

*Walk in centres is a good idea (HM1, 71y)*

*Health promotion activities are better in community setting as we can have a discussion with 'peers' (literally translated as other people, particularly elders with knowledge and experience of life) (HF5, 48y)*

*Education programmes helpful-but it depends on character of peer educator-can be off putting if character not good (HF3, 41y)*

***Moslem female focus group comments on the value of exercise (age range 30-70y)***

*Health education programmes would work if there were other activities (7). The main problem is 'time'. People do not want to participate if it was just a health fairs. We try so many (health) initiatives here at the community centre-all this effort-but people just bin the info and do not want to come. (5).*

***Probed How can we encourage attendance?***

*To get people out and about is a big problem. Many of us cannot come because of transport problems-because who will bring us if the men are at work? If (at health fairs) we have free food and free tickets-everybody will come-it's a question of money (5). As an elder, I would be very happy with this arrangement. Also we have to make the programme varied-but free food is a must! It will then be successful and people will listen. We held an AHM (Annual health meeting) -nobody took an interest when it was publicized-but it was re-publicised with food, drink and entertainment and it was packed!. If we had health fair with some entertainment-it would work. (MF1,3 and 5)*

**NHS Direct and Other Telephone help lines**

Participants were asked on their views about NHS Direct services. Most participants had not heard of NHS Direct or the availability of other telephone help lines. When the service was explained, mixed responses were received

*I am not used to this (speaking about health issues on the telephone). I do not know who gives me the information and will it be the same person again (HF3, 41y)*

*I also worry about confidentiality issues-will information be given to police? (HF4, 42y)*

*Telephone help lines 'have no personal touch'. This might be OK for minor problems. (HF5, 48y)*

*We would still use GPs rather than a telephone line. There is no assurance of confidentiality on telephone as we do not know who is on other end. It would work for the younger generation (PF3, 76y)*

*If telephone service is available, I would use it only for a second opinion (PF1, 90y)*

*It depends on the illness. It can be a time-saver. But I wouldn't use it-better to call the ambulance. Other family members get anxious, so telephone conversations with other people can be difficult when you have got anxious aunts and mothers around. (MM9, 39y).*

### **Computer use / IT**

Participants were asked if they accessed health information on the computer or via other information technologies. The researchers observed that computers were available at all the community centres where the interviews took place. Most participants admitted that they had never used the computer or used the computer to access health information. Most admitted that this was due to their perceived lack of education.

*It is better for the younger generation. We are not educated. I prefer talking to my friends and community members for more information. (PF3, 76y)*

### **Information on other health issues**

Throughout the discussions, the researchers noted comments participants made about issues they would have liked more information about. The following observations were noted from the Hindu and Moslem female participants.

*A video or more information such as 'Pharmacist's medicine cannot cure'-we need more info and awareness on this (HF2, 50y)*

*Can we have a video or similar entitled 'is it necessary to see the doctor?' (HF6, 45y)*

*Stress is certainly 'misdiagnosed' and I would like more information about it before I see my GP. I think it would be good if all of us knew a little bit more about these sorts of things. (HF 7, 60y and all in agreement)*

*I want more information on interactions and adverse effects (HF1, 42y)*

*Advice on alternative medicines (HF2, 50y)*

*I think information of what medicines you should take when going abroad is good-especially malaria. Malaria advice is important (MM3, 31y and MM5, 75y)*

## SECTION 6.2: Confirmation of the findings 2008

The author of this study considered it pertinent to ensure the validity of the interpretation of the findings from the data. Since data collection was completed, additional government policies had been introduced indicating significant changes to how community pharmacy services were to be delivered (refer to Table 5, Chapter 2 page 36). This included the introduction of the new Pharmacy Contract in 2005 (DH, 2005d) and introduction of some local enhanced pharmacy services, including a minor ailments scheme in Leicester City. Many of the findings that had emerged from the data needed to be reconfirmed for 'currentness' in light of the introduction of new policies and services. The findings during the original data collection period of 2001-3 illustrate the complexity of barriers and other confounding factors that the South Asian population describe in relation to access to community pharmacy services, some of which are substantiated or refuted by the health care professionals interviewed. The emerging categories and themes also encompassed similarities and differences between each participant set. The author has attempted to further contextualise the findings in order to discuss this in a meaningful, pragmatic way during the re-validation exercise. The findings of the study were re-confirmed in 2008 with one GP, two community pharmacists and six focus group participants (see Chapter 4, page 186)

The findings were discussed under three main headings entitled knowledge, communication and professionalism, which were interpreted by grouping themes and categories that best fitted the headings. A detailed 'mapping' process was undertaken to group themes and categories from the data, and this is illustrated in Appendix 10. The broad interpretation of these headings (for ease of discussion with the participants) is as follows:

**Knowledge:** Awareness and knowledge of important influences, including cultural influences, affecting health and health seeking behaviour patterns in the South Asians

**Professionalism:** The recognition of the community pharmacists and GPs as health care professionals and how this influences health seeking behaviour in South Asians

**Communication:** Communication, health promotion and education factors that influence health outcomes and interventions among South Asian populations.

One GP made the following comment:

*'It is interesting as I believe that the importance of the skills of using knowledge, professionalism and communication are what we are taught during out training. As time goes on we take this for granted. However, we seem to leave a whole community behind. I am pleased with the findings. I think more*

*work needs to be done especially for community pharmacist to be of value in our area. Please tell them to get out more and show us what they can do (GP 2008).*

### **Participants views of 'knowledge' and its associated themes (2008)**

Some quotes from this reconfirmation exercise confirm that the data supporting 'knowledge' and its associated meanings validate the original findings. The argument about 'free' services was commented on by the GP, and more needed to be done to promote the functions of the NHS, and in particular GP and community pharmacy services.

*'I still believe the NHS has created this, i.e free medicines and services. Back home, they have to pay for medication and a lot of Prescription Only Medication (POM) can be bought. Just because we are not seen to be in our surgeries 24/7 does not mean we do not do anything else. So knowledge of our processes and allocated times would help. (GP, 2008)*

*'I still don't know how (community) pharmacists can have an impact, particularly on people who have the mindset that it is only the doctor who can cure them' (GP, 2008).*

*'A lot of basic knowledge needs to be conveyed about pharmacists and their roles as health care professionals. In Saudi, India-all these countries, pharmacists play a different role in the communities. (GP, 2008)*

*'I think in principle (additional pharmacy services) is a good idea but it needs to be promoted in a way whereby people will use the service for which it is intended. The purpose of an enhanced service needs to be made clearer to both GPs and patients (GP, 2008)*

*'South Asians 'expect' medicines and will not leave without getting something on the voucher (for minor ailments enhanced service). It does take time to explain things to them but they still expect something, despite telling them not to stock pile (Pharmacist 1, 2008)*

*'Vouchers (for minor ailments schemes) are OK but only get cheap medicines on vouchers (FG participant 2, 2008)*

Knowledge of the use of alternative practitioners and practices was still prevalent.

*People do not mind going to vahids etc abroad because they have no choice but to go to them. I wish they would consult us before they do this (consult faith healers). But that is life and we are faced with this everyday in this community. All we can do is damage limitation. (GP, 2008)*

*'Wasn't xxxxxx (a preacher/faith healer with a large Hindu following) good? I was tempted to leave my BP tablets but I got worried so I did not. I find they do not agree with me. My feet swell up. The GP cannot do anything about this. But with the exercise Ramdev has shown me I feel so much better and my BP is now fine. It is a good feeling, but after he goes, I become stressed again. (FG participant 4, 2008 ).*

*South Asians expect 'cures' so they will take 'multiple' medication to get better. They consult abroad. But they still want western medication. They do come back having tried ayurvedic medicines and think it has not caused any harm. But, I have not seen any untoward reactions in people. **Probed-do you ask them?** Not usually (Pharmacist 1, 2008)*

### **Participants views of 'professionalism' and its associated themes (2008)**

The following quotes and comments from the confirmation exercise in 2008 illustrate that the notion of 'professionalism' and its associated meanings are still valid. The image of the 'shopkeeper' and 'consumerist' atmosphere in a community pharmacy setting is still important.

*'This is not just about professionalism but is also the pressures for us to do not just our jobs but more. We have a lot of other things we have to do. It may be different when you are in a shop, and visible.'* (GP, 2008)

*'We still have a shopkeeper image. I still sell nappies etc, but I sell what people want. I have to pay bills. If people do not pay for OTC medicines and all that, we find it difficult. I agree we have to portray a more professional image. The face of pharmacy needs to be revamped. We appear too boring' (Pharmacist 1, 2008)*

*Pharmacists need to be the 'peoples' professional and not promoted as a shopkeeper. (FG Participant 5, 2008)*

*The pharmacist seems to now come out from the dispensary to talk to us about our medicines. This is better. (FG participant, 2008)*

Despite the introduction of the new Contract, pharmacists still commented on other barriers.

*They (the government) need to invest in services and remunerate better. This is important for self esteem and trust. We know our clients. To work with South Asians is interesting and challenging, but given enough exposure and time we can make a difference. Our services need to be better tailored to suit their needs (Pharmacist, 2008)*



*The government wants all these changes but has not consulted pharmacists in my opinion. I do not advocate our Society-it has not promoted or protected us from this. Our fees have gone up-for what? Yet, the GPs have got a very powerful voice. (Pharmacist 2, 2008)*

*Many pre-registration students have come into pharmacy because they think it is a good well paid job, but I do not think they see themselves as health advisors first. They take this for granted (Pharmacist 1, 2008).*

*It is all about money. If we had the money, we could be given the opportunity to shine, improve our premises, have GPs and other health care professionals on our premises and this will show inter-professional collaboration (Pharmacist 1, 2008)*

The notion of 'trust' in pharmacy services was highlighted.

*The way they (community pharmacists) speak and the way they respect our needs. It is common sense at the end of the day. (FG participant 3, 2008)*

*Our patients come back and say sometimes that the GPs do not agree with our recommendations, so this 'mistrust' sets in. (Pharmacist 1, 2008)*

*It is good to see pharmacist first, but they do not give strong medicines. We still go back to the doctor. (FG participant 5 2008)*

*I was taken to a room at the back of the shop. I was not told why they are asking me about my medicines. I said I was taking them as how it reads on the label. I asked him (the community pharmacist) why he is asking again. I was left to believe that the doctor had made a mistake (FG participant 2, 2008 (lack of effective information from pharmacist doing a Medicines Use review)*

The following quote illustrates the need for a more sensitive and tailored service for this population

*What (additional enhanced services) works in Braunstone (a white working class suburb of Leicester) does not work here. We need more subtle and sensitive ways that certain issues are addressed and how this information is communicated, as we will not readily read a leaflet on this or even glance at it. (**probed-which ones?**); use of condoms, teenage pregnancy, breast examination, depression and all these issues. The leaflets and advertising is very insensitive and too open. For us, this can be done in more private settings with appropriate people who understand our cultures'. (FG participant 5, 2008)*

### **Participants views of ‘communication’ and its associated themes (2008)**

The following quotes and comments from the confirmation exercise in 2008 illustrate that the data supporting the theme ‘communication’ and its associated meanings is valid.

*With service users, I think communication is key. If you know the language, this can overcome the communication and professionalism aspect (Pharmacist 2, 2008)*

*We get too much information from too many people and this is confusing. So we do things that suit us best. (FG participant 7, 2008) (refers to patient information leaflets and health promotion initiatives)*

*We need time to promote leaflets and explain messages, particularly for South Asian patients. There is no consistency in their availability, and I find them difficult to get in other languages. (Pharmacist 2, 2008)*

*I prefer to go with a friend I trust or a GP who speaks my language. Otherwise I feel scared when he calls somebody else in who I do not know. (FG participant 8, 2008-use of language lines)*

*I do speak the main languages so it is not a problem. This can be difficult for non-Asian GPs and I know they have to go through family relatives to interpret. That (using family members or advocates) is OK as long as I get to the root cause of their problems (GP)*

### **Box 16. Key findings of Phase 2 (2001-3) and re-confirmation exercise (2008).**

Some of the key findings are listed below.

- The findings show a need for more pro-active and 'responsive' pharmaceutical services, where 'non-clinical' domains are also considered in service design and delivery.
- Different cultural influences and practices are prevalent within the South Asian community and South Asian people will carry on being influenced by this.
- Aspects underpinning the notion of 'cultural competence' in particular how South Asians differ both inter-culturally and intra-culturally and that there is a need to meaningfully interpret this behavior in relation to health seeking behavior and medicines adherence
- Insights into how medicines were used when abroad, the understanding that 'generics' were 'inferior' medicines, the impact of 'stress', how medicines were 'shared' and how medicines waste was viewed provided some intriguing insights to medicines adherence
- Professionalism in both pharmacists and GPs is valued by South Asian population, but inter-professional collaboration and communication needs to be enhanced for this population to have more 'trust' in services
- The importance of enhancing the pharmacist-patient relationship is illustrated and there is an opportunity for community pharmacy to engage better with South Asian service users in order enhance their image, knowledge, skills and attitude in relation to this
- The participants illustrated their beliefs of involving communities and religious leaders in health education and community health initiatives, and welcomed pharmacy input in this
- Health promotion activities in a community setting were welcomed. The use of translated leaflets (and indeed leaflets in general) was minimal
- Sensitive communication with South Asians revealed how 'stigmatised' conditions such as depression and contraception were perceived by this community, and how having these conditions have an impact on the individual and their 'acceptance' in their wider community

A synopsis of findings has been also illustrated in Figure 5 (page 342). The author believes that these findings cannot be considered individually, but that they are intricately linked and need to be considered in relation to a 'holistic' understanding of the main issues.

In the next section, the author discusses how South Asians regard current service provision by GPs and community pharmacists, and debates whether community pharmacists would benefit from acquiring further knowledge of diversity, health policy, cultural or socioeconomic differences and uncertainties, utilizing and further developing their professional and communication skills. Additionally, the author attempts to iteratively interpret the findings and debates the findings from a wider perspective of the pharmacists' role as a 'care-giving and holistic' practitioner on an individual level and also the wider population.

**Figure 5. Synopsis of the findings of Phase 2**



### **SECTION 6.3: Discussion of the findings from Phase 2 focus group interviews**

In this section, the descriptive findings from the previous section are discussed describing the values underpinning Asian communities' use of community pharmacy services and the pharmacist's role as a health care advisor. The literature reviewed in Chapters 2 and 3 showed that the evidence base demonstrating the value of community pharmacy services was sparse and that the studies underpinning Government policies were limited. The findings are critically discussed with the literature and contextualised allowing for a pragmatic discussion in relevance to pharmacy practice.

**Section 6.3.1** triangulates the key findings in relation to the key study by Jesson et al (1994b) and illustrates the limitations and strengths of the findings of this study compared to the study by Jesson et al (1994b).

**Section 6.3.2** continues with discussing the principal findings and their interpretation. The author contextualises and argues this against the literature relevant to the notions of medicines adherence in relation to culture, cultural competency, professionalism and communication, along with the author's iterative interpretation, adaptation and integration of the findings into practice.

**Section 6.3.3** summarises the strengths and limitations of the study. Although this study did not explore the views of the 'white' population, the author believes that the findings have added more depth into understanding the needs of the South Asian population, and that a similar study using a similar research methodology should be conducted to explore the pharmaceutical needs for all populations.

**Section 6.3.4** reflects on how the findings of this study have impacted on the author's professional practice

**Section 6.3.5** illustrates how some of the findings of this study have been integrated into the Minor ailments scheme in Leicester City (2008).

**Section 6.3.6** makes some recommendations for further study

### **Section 6.3.1 Triangulation of findings with the study by Jesson et al (1994b)**

The data for this study were collected between 2001 and 2003, and the principal investigator acknowledges that there was very little published literature relating to community pharmacy use by the South Asian population, which made the approach and planning the choice of the most appropriate methodology for the study challenging. For pharmacy, there was no other major study in this area since Jesson et al (1994b) who clearly advocated more research in this area. Table 31 compares and contrasts the main findings of the study by Jesson et al (1994b) and this PhD study. There are many similarities in the findings of both the Jesson study and this PhD study, despite being conducted almost 16 years apart. Many of the findings are similar to the study by Jesson et al (1994b), and the author has triangulated the findings of her study by using a different methodology. It is somewhat surprising that the recommendations of the study by Jesson et al (1994b) have not been further researched or evaluated until this PhD study. Particular gaps in the literature still showed that more research was needed to understand if this population differs from the white population in their management of minor ailments and a further exploration of their relationship with community pharmacists. There is considerable debate in the literature about the influence of 'culture' and 'cultural habits' that could have impact on health seeking behavior and this has been explored in healthcare settings outside the pharmacy domain. The findings of this study illustrate that, to some extent, the pharmaceutical needs and concerns of people of South Asian origin are not dramatically different from those of 'white' service users. However, differences of language, culture and religion are often important.

The findings of this PhD study illustrate additional insights to the Jesson study (1994b).

These include:

- Limited awareness of particular beliefs and attitudes relating to the health of South Asian ethnic minorities
- Limited professional collaboration between GPs and community pharmacists
- The lack of knowledge of GPs and South Asians' of the new reforms in the provision of community pharmacy services
- The extent to which socio-cultural factors influence the uptake of pharmacy based services, including:
  - public health initiatives (e.g. sexual health screening, contraception, health promotion activities including healthy lifestyles)

- influence of local community members and extended family networks ('lay referral systems') particularly for stigmatised conditions and the management of minor ailments
- deeper exploration on how 'cultural' influences' affect medicines adherence
- Lack of availability of interpreters in the community pharmacy setting
- Understanding aspects that contribute to the pharmacist-patient relationship in addressing pharmaceutical needs (e.g. consultation skills, trust, confidentiality, the availability of private consultation areas)

Some of these findings are critically discussed in relation to the present study further in this chapter.



**Table 31. Comparison between findings of the Jesson study (1994b) and this PhD study (2010)**

	<b>This PhD study (2010)</b>	<b>Jesson study (1994b)</b>
<b>Respondent profile</b>	6 GPs (SA and white) 5 community pharmacists (SA and White), 55 focus group participants (Moslem, Hindu and Sikh) Study with 'White' sample was not included	73 Black Caribbean community members 129 SA (Moslem, Sikh and Hindu) community members Study with 'white' sample done in a previous study
<b>Settings</b>	Inner city Leicester (Leicestershire)	Inner city Birmingham (Warwickshire)
<b>Research methodology</b>	16 Qualitative semi-structured interviews (5 with GPs, 5 with community pharmacists and 6 focus groups with SA participants)	Structured interview schedule (survey) with a mixture of closed and open questions
<b>Summary of findings from this PhD study (2010)</b>		<b>Main recommendations / findings (Jesson et al, 1994b)</b>
<b>Research methodology and ethnic minority health care research</b> Study used a qualitative methodology approach. Purposive sampling used. Recommendations made for monitoring ethnicity status. Social action research model used. Strong recommendation on collecting data on ethnicity. Considerations need to be given to cost implications of conducting research with minority ethnic communities		<b>Research methodology and ethnic minority health care research</b> Difficulty in getting a randomised sample for the study. Strong recommendation on collecting data on ethnicity. Consideration need to be given to cost implications of conducting research with minority ethnic communities
<b>Access to Pharmacy and GP services</b> For pharmacy, differences seen between independent sector and multiples. Difficulty in access to GP practices discussed by service users and pharmacists.		<b>Access to pharmacy services</b> Needs of ethnic minorities met by the independent sector and recommendations made to target this sector of pharmacy practice for future initiatives
<b>Understanding the pharmacists role</b> <b>Dispensing role</b> was considered to be the primary role by GPs and South Asian participants. South Asian Participants illustrated a 'variation' in the service and inconsistencies into whether they were being advised by a pharmacist or counter assistant.  <b>Advisory role for minor ailments:</b> All participants acknowledged that the advisory role was under-utilised, though		<b>Understanding the pharmacists role</b> <b>Dispensing role was acknowledged by participants</b> FHSA local budgets could be targeted to improve verbal communication regarding medicines. Findings showed inconsistencies in advice.  <b>Advisory role for minor ailments</b> needs to be better promoted to the South Asian community. The findings illustrate that the

<p>most South Asian participants were aware of the advisory role. GPs did not promote the use of the community pharmacist in an advisory role, except for the use of medicines that would be normally prescribed.</p> <p><b>Advanced and enhanced services:</b> (patient care roles) need to be better evaluated and promoted. The ideas were well received by all participants, though there were reservations from GPs and community pharmacists about the appropriateness of such services.</p>	<p>advisory role was under-utilised by the South Asian sample, particularly by the Moslem community.</p> <p><b>Patient care role</b> (examples of services such as diagnostic screening etc) would require further research into how such services would be perceived.</p>
<p><b>Cultural influences on the pharmaceutical care needs of ethnic minorities</b></p> <p>Issues regarding the Fast of Ramadan explored with all participants. Findings show that more information is needed on the clinical consequences of such influences.</p> <p>Travelling abroad had implications on compliance, and there is a need for more information on travel health.</p> <p>Alternative 'medicines' were mainly discussed as 'health foods'. Use of alternative medicines and practitioners explored and there is a need for better knowledge of the clinical consequences of these practices.</p>	<p><b>Cultural influences on the pharmaceutical care needs of ethnic minorities</b></p> <p>Fasting beliefs and habits significantly illustrated that there is still a need for health care professionals to understand this aspect. Advice on travel health needed.</p> <p>Alternative 'medicines' were mainly discussed as 'food' items' Use of alternative medicines and practitioners explored and there is a need for better knowledge of the clinical consequences of these practices.</p>
<p><b>Integration of pharmacy into the wider health community</b></p> <p>This finding added more depth to the recommendations by Jesson et al (1994b). Discussions with all participants showed the need for better professional collaboration and communication, and issues such as trust, competency and ways of enhancing the professional image of the community pharmacist were discussed.</p>	<p><b>Integration of pharmacy into the wider health community</b></p> <p>was a recommendation only.</p>
<p><b>Communication</b></p> <p>Additional issues to linguistic difficulties illustrated</p> <p>Lack of interpretation services discussed by all participants</p> <p>Translated information leaflets are not read</p> <p>Better ways of verbal communication needed</p>	<p><b>Communication</b></p> <p>Additional issues to linguistic difficulties discussed</p> <p>Translated information leaflets are not read</p> <p>Better ways of communication needed</p>

<b>FURTHER CONTRIBUTIONS</b>	
Views of community pharmacists obtained	
Views of GPs obtained	
Additional discussions on professionalism and professional image of the community pharmacists, including sensitive consultation skills	
Knowledge of the functions of the NHS needed for South Asians	
The findings indicate the need for private consultation areas within the pharmacy even for essential pharmacy services such as advice on medicines and preventative health, including health promotion.	
Knowledge of advisory role for preventative health and training of community pharmacists was poor in GPs and South Asian participants. This role needs to be better promoted.	
Better knowledge of cultural habits is needed	
Better knowledge of adherence with medicines whilst abroad: this should be explored in consultations	
Removal of cost barriers needed for enhanced services to succeed	
Use of telephone help lines needs to be further explored	
Implications for minor ailments scheme and wider pharmacy practice	
Discussion of how to manage 'stigmatised conditions', the need for understanding family and community participation in decisions regarding service design and delivery were also considered important.	

### **SECTION 6.3.2 Discussion of the main findings**

The findings of this study illustrate unique and valuable insights that ‘one size does not fit all’ and that there is no ‘unity’ of perspective, and that greater attention needs to be given to examining the pharmaceutical needs of specific minority ethnic population groups. Relatively little high-quality research has been conducted since the study by Jesson et al (1994b) , and even less on adherence-enhancing interventions for people of cultural and linguistically diverse backgrounds (Manias and Williams, 2010). Patient involvement and adherence are central to medicine-taking yet these areas are less well researched than medicines themselves (NICE, 2009).

General themes from the findings of this study can be confirmed with some earlier local studies in the literature (Eccles and Kohli, 1996 and Fassil, 1996). The findings of this also PhD study underpin that many beliefs are held by ethnic groups and must be further explored, acknowledged and respected by all health care professionals, and the concept of a better ‘responsiveness’ to health care needs is needed. Most focus group participants illuminated the researchers about some of their cultural habits and beliefs and how they interpreted their health, health seeking behavior in relation to these factors. It was important for them to express their views in order to establish a relationship with the researchers in order to understand and appropriately interpret their experiences in a meaningful and engaging manner. The debate of ‘cultural’ issues and how they impact on health and health seeking behaviours in the South Asian community has been widely discussed in the non-pharmacy literature (see Chapter 2 pages 26-31 and Chapter 3 pages 104-113). Many of the authors argue of the danger of the assumption that “non-compliance” with ‘universal’ health and lifestyle advice is always attributable to “cultural factors”. The argument that populations are different because they are from a different ‘culture’ and need to have ‘separate’, ‘other’ or ‘different’ modes of service delivery can lead to harmful ‘stereo-typing’. Whilst the author of this PhD commends these debates, the findings of this PhD study shows that it was still frustrating that the literature on how community pharmacists could contribute to these debates for the general population has not received attention. National templates embedded within national frameworks and policies do not indicate flexible ways to allow pharmacy services to be tailored for local population needs, and even more so particularly for areas with diverse populations. This is confounded by the lack of research in pharmacy practice in such population groups. The findings of this study illustrate that community pharmacists are integral to healthcare provision, but they also need to embrace both the broader social and political context within which behaviour change in both the majority of the population and minority ethnic groups are placed.

It can be also be suggested that community pharmacists need to learn generic 'cultural competency skills' to respond flexibly to encounters where ethnicity and diversity have an impact, and whilst it is important to assess and respond to each patient as an individual, it is more important to be aware of variations, 'flexibility' and 'fluidity' in patients' 'culture' in its broadest sense. This does not mean that community pharmacists start to 'learn' cultures in a programmatic way so that these cultural sensitivities can be applied to patients who 'belong' to that culture, nor is it practical in the practice setting to use an approach that is only based on individual patients. Instead what the author of this study proposes is that, through a combination of formal education, self-directed learning and experience, community pharmacists widen their knowledge about cultural practices pertinent to their local population. This does not mean primarily 'learning' these practices through fixed 'lists' and protocols. Rather it means that the experience of having one's mindset about their working environment challenged, widened, or reformulated can help develop a more 'open' thinking that is more responsive to possible variations in patient preferences and needs, variations that may deviate from their usual day to day set practice. Once these domains are identified in the community pharmacists' mind, all patients may be asked how the proposed treatment may affect them, and negotiating the course of action with the patient can then begin. This is just as applicable to all population groups. The findings of this PhD study suggests that people's meanings and needs can be better understood by listening to what they say about their own health. Community pharmacists' approach should be responsive and tailored, and where appropriate, accompanied by attention to 'cultural' knowledge of their local population.

The discussions with South Asians in this study were very positive about community pharmacy for services for 'consumerist' expectations (such as delivery of prescriptions or the 'supply' and advice related to prescription medicines). They welcomed the idea of extended services and health initiatives could potentially be provided through community pharmacy, and that community pharmacists could also, if given the opportunity, enable themselves into acquiring more knowledge about South Asian 'cultures' and health beliefs. In the following discussion, the author discusses the findings in relation to the literature underpinning the notion of 'culture' and the argument for community pharmacists to be 'culturally competent', encompassing the broadest definitions and notions of this and relate to a more caring, holistic pharmaceutical service based on the model advocated by Hepler and Strand (1990). The author of this study strongly believes that 'ccultural' competence requires community pharmacists to value diversity, assess themselves and their understanding of their own 'culture' in relation to pharmacy practice on a regular basis, manage the dynamics associated in a population which may be a culture different from their own, acquire and use cultural 'knowledge' of that population and adapt to diversity of the individuals they serve. By

being 'culturally competent' the pharmacist can build rapport and trust with the patient, making it easier to work with the patient to improve health outcomes.

Specific themes from the findings of this study, in particular, the findings relating to culture and its relation to health and health seeking behaviours correlate well with the findings and supporting interpretations in the medical and socio-medical literature (e.g Lambert and Sevak (1996), Kelleher and Islam (1994), Greenhalgh et al (1998), Johnson and Verma (1998), Ali et al (2006) . Most of the authors of these studies illustrate that people selectively draw on elements of their culture and experiences to help them manage their health problems. As far as community pharmacy services are concerned, the findings of this PhD study do give a better insight into how South Asians view their health and health beliefs and how they find a sense of support from seeing themselves as part of a 'community' which gives them a sense of belonging and identity. The findings of this PhD study illustrate that understanding the cultural habits of South Asian service users does not consist of a 'list' of answers or solutions, but depends largely on continuing negotiations with patients and their families. Indeed, it can be argued that attending to the needs of minority ethnic clients may result in an improved service to all users of community pharmacy services, as, in some respects, the findings did not seem to be strikingly culturally specific either to the South Asian sub-groups in particular or the general population. The 'social' perspectives of the findings of this PhD study illustrated how and what South Asian people perceive as relevant in the day to day management of their health and how they integrate such constructs within their lives. This is just as applicable to the 'white' population. Community pharmacists should attempt to understand these 'social' behaviors and contextualize them in relation to modern pharmacy practice.

Programmes for incorporating diversity and 'cultural competency' education and training have been embedded and integrated in some depth in the pharmacy undergraduate curriculum in the United States and consideration should be made for embedding such programmes in the UK. (see recommendations page 382). The author of this study also recommends that such a programme could be potentially useful for post-graduate or professional development of practicing pharmacists and their staff. Because community pharmacy services are being reconfigured to focus on particular domains of interest such as medicines adherence and public health initiatives, the findings illustrate why it is important for community pharmacists to be better informed of how their service users interpret their own health in relation to their social, psychological and medical circumstances. With this growing awareness of diversity, community pharmacists are then better placed to ask all patients about their preferences with regard to what can be achievable. The findings clearly

show that community pharmacists' knowledge of their population demographics and the pharmaceutical needs of their local population was lacking. By further interpretation of the findings from this PhD study and the literature, the author discusses some areas where pharmacy services for all patients might be improved.

### ***Health seeking behavior and the management of minor ailments***

The findings illustrate that the term 'minor' can be 'misinterpreted' by South Asians whose first language is not English. It would be even more difficult if explanations on the management of these conditions needed to be given verbally in a South Asian language and as an investigator, this concept was difficult to explain to South Asian participants without using appropriate examples to illustrate the meanings. The literal translation of 'minor' is particularly difficult in many South Asian languages (e.g. 'chhote' in Hindi; 'jinni' in Gujarati) and these could be translated back into English as 'small', 'little' which loses significant meaning as 'minor'. A significant number of South Asian participants commented on the expectation of a prescription of an antibiotic for relieving minor upper respiratory tract symptoms such as simple colds and coughs. Duran-Tauleria et al (1996) argue that children from the Indian sub-continent were more likely to be prescribed simple 'cough medicines' by GPs for asthma symptoms as the underlying symptoms of 'wheeze' may not be divulged by the patient. Hence a diagnosis of a 'minor' condition could be inferred. The expectation of an 'antibiotic' for self limiting conditions is confirmed in the literature for the white population (Butler et al, 1998 Kumar et al, 2003,) and is the focus for recent government policies on the use of antibiotics (HPA, 2008b), which predominantly rely on written leaflets for education. In his paper, Johnson (1996) also cites some studies regarding 'somatisation' of symptoms in the context of the development of psychiatric screening instruments. Their conclusion is not that Asian patients have difficulty in expressing themselves, but that they tend to use somatic metaphors which are poorly understood. Johnson (1996) also argues that the use of interpreters can lead to loss of up to 50% of information as well as hindering rapport. This requires the use of skilled (and properly trained) bilingual staff, and practitioners must ask simple questions and be aware of the clients' background and possible cultural reticence either in replying or expressing uncertainty. It was also seen from the findings of this study that many South Asian patients present with 'overtly' somatic symptoms' and that a deeper 'probing' was necessary to understand the causes. This requires the community pharmacist to acquire appropriate consultation skills which are different to the mainly 'reactive' counselling skills used in current practice. This argument is also supported in the Government latest health policy reforms, in particular from a patient-centred focus and to meet the government's anticipated aim of '*no decision about me, without me*' (DH, 2010).

South Asians participants' knowledge and comments about 'over the counter medication' was more encouraging than community pharmacists reported. However, in this study factors such as the cost of purchasing a medicine to improve the self management of minor conditions were an important barrier that prevented South Asians from going to the community pharmacist as a first port of call. Medicines could be obtained 'free' if they are issued on a prescription, particularly for patients exempt from paying prescription charges. This is also confounded by the lack of acceptance and uptake of the pharmacists' role as a health care advisor by this community. These findings are congruent with the findings of the pharmacy studies by Hassell et al (1996, 1998, 1999, 2000b), Bero and Bond (2001) and Schafheutle et al (2002). The study by Hibbert and Bissell (2002) (Chapter 3 page 82) shows that in many cases patients have already decided what product they need and that the pharmacist's assessment of symptoms is often in response to the patient's request for a product as opposed to assessing the actual symptoms. This finding contributes to the debate of the findings of this PhD study for the establishment a better 'pharmacist-patient relationship'.

South Asians participants welcomed the use of private consultation areas for 'minor ailment' consultations, and this was confirmed to be the case with the white population in studies by Bojke et al (2004) and Puntong et al (2008), which were conducted after data collection for the current study. In the UK pharmacists' undergraduate curricula and vocational training includes the ability to recognise and respond to symptoms relating to minor ailments and act appropriately to ensure patient safety. Whilst this role of the community pharmacist is well recognised in the wider literature for 'white' communities, the training of pharmacists in this area does not specifically entail the need to do the consultation in a private consultation area. If the question about the need for privacy is not asked it cannot be assumed that South Asians require privacy more than others.

The findings of this PhD study are also enhanced by a study conducted by six years later by the Proprietary Association of Great Britain (PAGB, 2009) , which explored the attitudes and behaviour of consumers, patients, GPs, nurses and pharmacists in understanding the drivers and barriers for self care of minor ailments. The study by the PAGB did not show breakdown by ethnicity, and used both qualitative and quantitative methodologies. The findings of the PAGB study showed that better knowledge was needed for members of the public about self management of minor ailments, trust in the pharmacist's advice, that GPs and nurses have less confidence in the pharmacist. Consumers also said that pharmacists spend little time out of the dispensary, and that many consumers go to the nurse or GP for 're-assurance' of their symptoms.



*'Generally GPs/Nurses are too willing to prescribe and lack confidence in pharmacists so need 'permission to act' to break this cycle' (PAGB, 2009).*

In this PhD study, the insights given by the South Asian participants add value to this debate, in that certain health seeking behaviours may be due to 'exaggerated' presentations, or presentations that may need a deeper exploration by the pharmacist. This needs to be done through 'open' questioning in the first instance, and for community pharmacists to be more pro-active in their approach. In the author's opinion, this endorses the argument for better consultation skills in the first instance.

### ***Understanding mental health and other 'stigmatised' conditions***

In some therapeutic areas, particularly psychosomatic disorders (such as depression) and conditions where patients cannot describe overt symptoms (such as hypertension), community pharmacists may need to question patients in a more sensitive manner to get an accurate history of their complaint. The findings from both phase 1 participants and Phase 2 focus group participants illustrated that 'mental health' issues are considered to be very 'taboo' and that such problems would normally only be discussed by South Asians in an appropriate 'social' environment with people within their own social communities. When South Asian service users, particularly some Sikh and Hindu participants were probed about mental health conditions, they became very nervous discussing such issues with the researchers. Some GPs implied that there could be cultural explanations that could contribute to the 'reluctance' to discuss such issues with health care professionals. The issues surrounding the discussion of mental health and more 'stigmatising' issues illustrates the complexity of perceptions that GPs and service users have about the consultation processes and the confounding factors that influence consultation processes, confirming that 'knowledge' needs to be a 'two-way process' between the health care professional and the service user. In the author's professional experience, the presentation of certain symptoms like thrush and discussion of sensitive issues relating to contraception and sexual health within community pharmacy may not be as 'open' as observed with the white population. Although these behaviours cannot be considered to be 'different' or 'unique' to this population, it is helpful to understand inter-cultural differences in the way the consultation patterns are interpreted in different populations. The findings of this PhD study gave further insight into such observations. Moslem focus group participants in particular wanted more recognition for wider community 'involvement' and the respect for their cultural 'norms'. For pharmacy, an illustration of how adherence to asthma medication can be 'negotiated' through knowledge of 'cultural' beliefs is illustrated by Murphy and Tallis (2003). The case illustrates that conditions such as 'asthma' can also be considered as 'taboo' or 'associated with a stigma' particularly in women with marriage prospects in the South Asian community.

The authors suggest that 'compromises' need to be reached through sensitive negotiations and the will of the patient to use their medication in a manner appropriate to their social and cultural 'norms'. This could also impact on building 'trust' in the health care professionals. Other examples are also discussed within the medical literature. Wright et al (2000) suggest that factors such as the fear of the social stigma associated with epilepsy and learning disability may contribute to lower consultation rates in these communities, and this could also be confounded by religious beliefs (Ismail et al, 2005). Although these are not necessarily classified as 'mental health' issues by professionals, South Asians can interpret these as such, to affect their relationship with health care providers and their status in their community. Further examples are also illustrated in studies with South Asian communities by Dogra (2005); Kumari (2004) and in studies of infertility (Culley et al, 2007). Reviews by Culley and Dyson (2001, 2010) further discuss such issues for practicing health care professionals. The author of this study suggests that an exploration of South Asians' perceptions of health, mental health or otherwise, should be sensitively explored in order to have a more meaningful intervention in understanding the different ways in which patients present with symptoms (or not as the case might be) and further understanding the implications of this on medicines adherence and health in general. Participants shared their experiences and thoughts on issues of confidentiality and trust and preferred these issues discussed in a 'closed' setting depending on the sensitivity of the issues. 'Familiarity' or 'familiarization' of healthcare professionals within the community 'network' were considered important. Community pharmacists need to be aware that service provision in health areas that would be viewed as 'highly sensitive' would need to assure South Asian service users not just of the strict code of conduct underpinning data protection and confidentiality, but understand that the need for confidentiality. This cannot be explained due to 'stigma' on its own, but other factors such as family and community acceptance support and confidentiality was also important. In addition, policy makers need to be aware that public health initiatives such as Chlamydia screening (and its impact on child-bearing prospects) or the provision of contraceptive advice or emergency hormonal contraception may need to be appropriately promoted and configured to meet the needs of ethnic minority service users. Other studies with 'white' populations have also shown the need for private consultation areas in community pharmacies, and some services requiring private consultation areas such as emergency hormonal contraception has been successfully evaluated in the 'white' population (Anderson and Bissell (2004a). However, another qualitative study by the same authors illustrates concerns of users of the scheme, and the issue of ethnicity and acceptability to minority ethnic users of the scheme would need to be further explored (Bissell and Anderson, (2003a), Anderson and Bissell (2004a). These findings are also supported in studies by the Health Protection Agency (2007) and are not unique to just the South Asian

community. In addition, the views of community pharmacists themselves on their views of the 'ethical' supply of emergency hormonal contraception needs to be further explored as it cannot be assumed that such services may challenge their ethical obligations and their religious beliefs. Such notions were not specifically probed for in this study.

Participants also discussed that they would need to 'trust' healthcare professionals to keep the consultations confidential. More specific comments were made about their perceptions of illness in relation to their social status within their communities. Although most comments about the availability of private consultation areas were not directly aimed at minor ailments conditions per se, their use is advocated by the findings of this study. The investigator of this PhD study endorses that private consultation areas are essential for such services, but the findings of this study suggest that further exploration is necessary in order to establish whether such services will be used by members of this population. It can be argued, however, that this is not unique just to South Asians, nor can it be just attributable to 'cultural' factors. The findings illustrate and enabled the author of this study to recognize that culture is a dynamic entity, and that community pharmacists need to recognize 'culture' in this light, and incorporate fresh ideas and responses to this 'fluidity' as people develop new ways of responding to their environment and also when their health and medical needs are influenced by their social, psychological and community needs.

### ***Diet and lifestyle (including exercise)***

This study illustrated the importance of the recognition of some of the differences of the understanding of the importance of appropriate diet and healthy lifestyles in the health and health beliefs of South Asian minority ethnic groups. Much of the medical and pharmacy literature focuses on the importance of promoting healthy lifestyles to this particular population because of higher prevalence of diabetes and coronary heart disease. In this PhD study, South Asians illustrated good awareness and understanding of the need for healthy diets and lifestyles. What was different was their interpretation of how they engaged with this knowledge according to their cultural beliefs for example, how diets are adapted to their religious beliefs and festivals. Their understanding of what constitutes 'exercise' was also interpreted within their beliefs and knowledge, and with some participants, this knowledge was limited. There is an opportunity for community pharmacists to engage with their patients but, for the intervention to be more meaningful community pharmacists must acknowledge the cultural context in which health and illness is expressed by this population. Grace et al (2008) also argue that powerful effects of 'social norms' on an individual's behaviour suggests that education and raising awareness alone may be insufficient to effect change in behaviour for some individuals. The researchers highlighted important moral

conflicts between individualist and collectivist goals (for example, the individual goal of healthy eating compared with the shame to the family of not providing guests with generous “special menu” food), and even second generation participants struggled with these conflicts. They suggest that contemporary health promotion is (arguably) built on assumptions of ‘individualism’ and ‘self investment’ and may need to be rethought for societies with a collectivist history (such as the Bangladeshi community in their study).

### ***Influence of community members and leaders and the ‘lay referral’***

As Kelleher (1996) emphasises, addressing the health needs of South Asians with strong traditional beliefs is a problem of integrating two systems of knowledge. For community pharmacists this is an interesting but challenging dilemma. It is one that has to be faced if they are to deliver modern services envisaged in the new Pharmacy contract to people with such a strong traditional belief system in order to integrate modern medical knowledge with their own beliefs. In their study, Kelleher and Islam (1994) suggest the ideas of self-help groups where people with a particular illness can meet, can be seen as places where they can share experiences and learn from each other in a non-coercive way, where ideas about treatments and how they work can be offered for others to consider, where the kind of exploratory talk which goes on can be seen as an example of what has been called ‘communicative action’. The findings of this PhD study show merit for such action research and other studies have illustrated this (Farooqi and Bhavsar, 2001; Bandesha and Litva, 2005.) However, the ‘added value’ role of the pharmacist in such activities could be further accepted if they were part of such community initiatives. Although this is advocated in the policies, the findings of this study show that there appears to be very little change in current processes within in the contractual arrangements, apart from some local examples of good practice. The findings illustrate this point in relation to ‘stigma’ that is associated with certain conditions (as discussed above), and the importance of ‘community acceptance’ in resolving such issues.

Pharmacists can offer to discuss problems and solutions to issues relating to service users’ day to day health management. In this study, South Asians gave a unique insight of their understanding of public health issues and had good awareness of the value of diet and exercise, but their reasons for some ‘deviance’ from the ‘modern’ explanations of such initiatives needs to be further explored and, in doing so, drawing on a combined understanding of their experiences of professional health-care and sharing ideas about what can be integrated into their culture. The author also observed how the interviews with South Asian participants were influenced by community ‘dynamics’ and group member influences. From the author’s practical experience, such ‘negotiations’ and ‘discussions’ were powerful

insights on how such sensitive issues and messages could be more meaningfully relayed in a community setting. Such arguments have also been illustrated in the medical literature by Greenhalgh et al (1998), Grace et al (2008) and Culley et al (2004; 2005), and in the wider social literature (Hillier and Kelleher, 1996), but need to be meaningfully utilised within the community pharmacy setting, particularly in understanding issues related to public health and medicines adherence.

### **Factors affecting medicines adherence**

What was even more interesting in this study is the exploration of factors underlying possible non-adherence to medication, which has not been discussed as such in the wider literature relevant to ethnicity, culture and health. Such views might be of interest to pharmacists, who are in a unique position to explore more holistic approaches to the use of medicines rather than those of just patient safety, quality control of medicines and ensuring compliance as directed by prescribers. South Asians in this study were very engaging once they built a rapport with the researchers, and through 'communicative' action research, the principal investigator had opportunities to explore, explain and educate focus group participants. Such 'action research' interventions have been successfully adapted and advocated in other studies with South Asian participants (examples include Farooqi et al, (2000), Farooqi and Bhavsar (2001), Johnson and Verma (1998), Culley et al (2004, 2005)). South Asians in this PhD study inferred the need for a more 'responsive' service, moving away from the 'one size fits all' or 'universal' model to one which offers choice and has the flexibility to meet the range of needs of the local population, particularly the needs of people in disadvantaged or underserved groups, and this has been advocated by government policy. (DH, 2003d). The findings of this study are further enhanced by further government initiatives, whereby service providers are being encouraged to design their services and clinics around the specific needs of their patient population, to listen to patients and to respond to their concerns and expressed needs (DH, 2008f). With the introduction of the 'medicines use review' advanced services, the community pharmacist has an ideal opportunity to also explore how some of these factors could impact on health behavior, which in turn could also give valuable cues to further question patients about medicines adherence. Some of the issues are illustrated below.

### ***Use of generics, 'sharing' medicines and medicines waste***

The findings from this PhD study shows that generic substitution (especially with generic medicines that have been imported from countries outside the UK) may have a negative effect on drug adherence because of concerns and misconceptions (see page 301). Greater awareness would need to be raised about South Asians' knowledge of the efficacy of

'generic' medicines as this could have implications on medicines adherence. Their understanding of 'generic' medicines as being 'inferior' or 'cheap' could be a significant factor leading to possible non-adherence and warrants further exploration using appropriate interviewing techniques during medication use reviews. This would be an excellent education opportunity for community pharmacists to engage in such activities and many South Asian participants welcomed the input of pharmacists to clarify issues regarding their medication. The interpretation of 'cheap' medicines for 'generic substitution' has also been further illustrated in the study by Lawton et al (2005) who explored the use of oral hypoglycaemic agents in Pakistani and Indian participants in UK, when participants considered the medicines available in Britain to be superior to those on the Indian subcontinent. Problems result primarily from inadequate information caused by language barriers but also from culturally conditioned views on encounters with the health care system.

### ***Medicines adherence whilst abroad***

A majority of participants in this PhD study did travel abroad to their place of birth or to the Indian sub-continent. Most participants from the Moslem background were more forthcoming about travel health and safety. Most favoured getting the information about vaccination from community pharmacists. Being aware of South Asians' travel arrangements such as religious pilgrimage (Umrah and Haaj), Hindu pilgrimage (Jhatra) and visiting friends and family abroad to countries where there is significant risk of contracting tropical diseases can be important health concern. Although community pharmacists were aware of such practices, the cost of appropriate anti-malarials was raised as an issue by focus group participants (page 312-3). This prevented them from purchasing appropriate medication; as such medicines are not available on the NHS. The issue of health care whilst abroad is an important one (Goodyer, 2004). Travel to the Middle East, African or South Asian sub-continent incurs the need for preventative measures, including vaccination against contagious diseases and the prevention of malaria. However, the knowledge of benefits of protection outweighing the risks needs to be promoted as an important emphasis rather than the overriding cost of medication and prevention strategies. This finding has also been confirmed by recent major report by the Health Protection Agency (HPA, 2008a) as part of its major recommendations:

*'Consideration should be given to making chemoprophylaxis for malaria more affordable to those travelling in family groups to at-risk areas, to reduce financial barriers to protecting all family members.....in regions where there are a high number of*

*malaria and enteric fever cases, public health and health promotion professionals should actively engage with community leaders to contribute to travel health programmes for at-risk ethnic groups, so that health messages can be communicated effectively and appropriately'. (HPA, 2008a).*

Jesson et al (1994b) showed that over half the participants in their study that had travelled abroad to their country of origin had sought professional advice on their health, mainly from the GP. Despite the confirmation of the findings of this study to the Jesson study previously (Jesson et al 1994b) and national recommendations by the HPA in 2008, there are no known local pharmacy or public health initiatives commissioned by local primary care trusts in Leicester City (or indeed, elsewhere) to respond to such recommendations. An ideal opportunity exists within the new Pharmacy Contract for community pharmacists to be central in a public health education initiative. In addition, suggestions for further exploration include the commissioning of a local enhanced pharmacy service to obtain anti-malarial drugs and vaccines, for example using proposals for incorporating the use of appropriate patient group directives for patients particularly at risk.

It was interesting to note that all participants commented that their health was 'better' whilst abroad and that the better weather seemed to improve their health, including improving long term conditions such as hypertension and diabetes. GPs and pharmacists need to be aware that concordance to medicine initiated in the UK may be compromised when patients go abroad and that South Asian service users may not divulge this information during a consultation. Participants openly discussed how 'stress' impacted on their health, and some admitted that their adherence to medication changed when they were abroad because they were less 'stressed' and 'felt better'. Some Hindu South Asian participants said that they consulted 'health care services' whilst abroad, and that they were also influenced by religious leaders and practitioners who hold significantly large gatherings and meetings. It is important for community pharmacists and GPs to be aware that such health seeking behaviours may not be divulged in consultations for the 'fear' of reprisal. For this PhD study, this is a new finding in that exploring medicines adherence in people whilst away or on holidays has not been formally researched in the pharmacy literature. The exploration of how 'stress' impact on health has been identified in the medical, social and anthropological literature (examples include Helman, 1990; Lambert and Sevak, 1996, Higginbottom, 2008). The author of this study suggests that this area should be sensitively and empathetically explored during a medication review, and could be considered as part of the new MUR service.

### ***Impact of fasting on medicines adherence***

All Moslem participants commented that the most significant aspect of faith & culture that impacted on health and medicines adherence was the fast of Ramadan. The health implications of the Fast of Ramadan have been extensively reviewed in the medical literature. It was interesting to note that pharmacists relied on their own knowledge of how medicines were used in this period, but none of the pharmacists, including the South Asian pharmacists, commented about where to get such information. The findings from the South Asian focus groups also show that such issues such as this need to be explored in a sensitive manner during a medicines use review and community pharmacists would need to be given guidelines on how to approach this topic. More importantly, these recommendations would need to be agreed with local GPs and other healthcare professionals, as well as local community religious leaders. Further research is needed on how community pharmacists can actively engage patients in a more meaningful and sensitive manner during a Medicines Use review during the fast. Moslem focus group participants were particularly vociferous on the issue of 'permission' to take medicines from their local religious leaders on this topic. The recommendations from the literature on Ramadan and its implications have been incorporated into pharmacy guidelines for diabetes (personal communication, Aliya Gilani, health inequalities pharmacist, Glasgow, Dec 2009) and a useful policy publication on the topic has been produced in 2007 by Communities in Action (2007). Further insights about 'fasting' were obtained from some Gujarati focus group participants guided by a religious observation, but they did comment that this was out of choice and that it was not a 'strict' as the fast of Ramadan. What was not evident is how these 'deviances' in fasting habits affect medicines adherence amongst the Hindu participants. Future research should further explore reasons underlying non-adherence concerns of this nature with other communities and faiths.

### ***Use of complementary medicines and alternative health practitioners***

The findings illustrated that South Asians used home remedies and some also consulted alternative practitioners such as hakims or vahids, either in UK or particularly when they went abroad. Participants commented on use of 'simple homemade' medicines and also that 'herbal' medicines available overseas were deemed to have no 'side effects'. Allopathic medicines were perceived to have many 'side effects' and some participants admitted to have sought the advice of alternative practitioners (e.g. Ayurvedic practitioners and Hakims) as a 'back-up'. The findings illustrate the opportunity for community pharmacists to explore such issues and beliefs during a Medicines Use Review (MUR) as part of the advanced contract within the new contractual framework. In Phase 1, the findings also illustrate that



both community pharmacists and GPs should have some more guidance of such issues, including access to information about possible interactions with allopathic medicines and knowledge of their clinically significant consequences. More specific guidelines on such interactions have been published since this PhD study (Williamson et al, 2009). It can be argued that sensitive 'negotiation' of adherence to allopathic medication alongside such modalities would require appropriate consultation skills in order to get a trusting relationship between pharmacists and South Asians, as the findings illustrate that such issues are not discussed readily due to fear of 'reprisal' from GPs.

### ***Influence of faith and spiritual beliefs on health***

The concept that health beliefs and healing were dependent on fate (karma) was prevalent in focus group discussions with South Asian participants. As with 'cultural' knowledge there are clearly differences in the level of awareness and knowledge about spirituality which form barriers between service providers (both GPs and pharmacists) and their service users, who then feel that their professionals are lacking in a significant area of knowledge. This has been shown in several studies (Johnson and Verma (1998); Webster et al (2002), Ismail et al (2005) and discussed in a review by Johnson (2004b). It is argued that religious belief can be used as a way of dealing with and making sense of illness. Lambert and Sevak (1996) argue that the intensity of religious belief may be found in many populations, and that the 'pious' in all populations may have more in common than the less religious persons of the same ethnicity or religion. The author of this study noted such observations particularly in the Hindu focus groups, where male and female participants differed in their interpretations of, for example, the religious implications of fasting within the Hindu subcultures.

### ***Professionalism, trust and the pharmacist-patient relationship***

The emergence of 'professionalism and professional image' emerged as a substantive theme in this PhD study. The author wishes to emphasise that whilst the introduction of new pharmacy services could be to improve access to GPs, the findings of this study illustrate that South Asians would need to trust the community pharmacists' role as a health care professional in the first instance. The wider literature shows that this population relies heavily on GP services. The findings of this study also illustrate that this population relies on the GP to make an initial diagnosis and re-assure them of their symptoms. The Pharmacy White papers (DH 2000b and 2003a) state significant changes to community pharmacy services by the introduction of 'advanced' and 'enhanced' services, many of which have been traditionally delivered by other health care staff including GPs and nurses. South Asian participants were unaware of new advanced and enhanced pharmacy services envisaged in Government White Papers. South Asian participants also discussed the fact that that they

were unaware of any local initiatives that promoted pharmacy services generally. The findings of this study illustrate that South Asians still have very 'stereotypical' views about pharmacists as 'dispensers', as did the GPs. This was also confirmed by the findings in the study by Spencer and Edwards (1992) who recommend that better evaluation of extended roles of community pharmacy was necessary, but the authors did not comment on exactly how they perceive this to happen.

South Asian participants' perceptions indicated that pharmacists need to improve their professional image in order to enhance their value and trust as a healthcare professional. Community pharmacists were perceived to be the 'dispenser' of medicines and in most cases a 'shopkeeper' and businessmen. There were varied responses to the pharmacists' role as a health care advisor. Cost barriers were cited as an important issue that prevented this population from consulting the pharmacist for advice on minor ailments. Interestingly participants perceptions that pharmacists could not 'diagnose' their conditions, even if it was considered 'minor', and their interpretation of 'minor' needed to be sensitively and appropriately interpreted and communicated during the interviews (discussed later). The recognition of the community pharmacist as a health care professional in their own right was not evident as most participants commented that they had no information or re-assurance of the training pharmacists and pharmacy staff had received. An older study by Partop et al (1986) showed that less than 50% of the south Asian sample in the study demonstrated that their knowledge of the pharmacist's role was poor. The study by Jesson et al (1994b) indirectly endorses the 'shopkeeper' image held by some of the South Asian participants. 'White' participants in the study by Williams et al (1992) and Boardman et al (2005). It can be argued, that although extended roles would be acceptable, better 'marketing' needs to be done to promote the role of the pharmacist (Jesson, 2007 ). The findings of the study by Jesson et al (1994b) showed that fewer than 30% of South Asian ethnic minority sample in that study had sought advice from the pharmacist. Jesson et al (1994b) concluded that more research was needed for South Asians, and this was confirmed by several major studies (Hassell, 2000b; Anderson, 2002). In particular, the Moslem community in the study by Jesson et al (1994b) were the least likely to have sought advice and most to believe that it was not the pharmacists job to give health advice. However, in this PhD study, the data illustrates that Moslem participants in particular were complimentary about the advice that they were given relating to medicines and were positive about their experiences of community pharmacy services, and that it was the Sikh participants that were particularly 'hard to reach'. However, it must be emphasized that the enthusiasm for improving and understanding the role of the pharmacist as a healthcare professional was welcomed by participants only when participants were better informed of these roles. Community

pharmacist participants in this PhD study endorsed the fact that their own role as a *health care professional* is not well promoted to their service users. This finding also conflicts with the idea of 'professionalism' and that 'professional collaboration' would be questionable if GPs were not aware of the community pharmacists' professional training, and further confounded if community pharmacists are to be acknowledged in their health advisory role to the South Asian service user. South Asians said that they did not see pharmacists as health advisors and this is also confirmed in later studies such as NHS Leicester City Residents survey (Ipsos Mori, 2008) and the PAGB study (PAGB, 2009), which were both done after data for this thesis was collected. It is apparent from the literature that such issues have not been resolved, and that there has been minimal change in how community pharmacy services are perceived by members of the general public (DH, 2008d). The findings do show that South Asians would welcome the provision of 'new' or 'reconfigured' pharmacy services and illustrated factors that confounded their perceptions of pharmacists as a health care professional in their own right.

South Asian participants argued that the community pharmacists offered advice with a (prescription) medicine and that such advice (when offered) was well received and accepted. This further confounds perceptions of the pharmacists' professional role as an advisor on 'medicines' as opposed to 'health advisor'. The apparent perception of pharmacists as businessmen or business owners was one that all participants in this study agreed needed to change if the pharmacists were to be viewed as a 'health care professional' in the first instance. There is a clear disparity in service provision, confounded further by the lack of uptake of the advisory role and the difficulties in communication. The participants in this study iterate that community pharmacists need to make themselves more available for proactive advice. Such initiatives have been proposed since this PhD study by way of devolving pharmacists' responsibilities to 'accredited' checking technicians, as advocated in the New Pharmacy Contract.

The original aims and objectives of this PhD study did not aim to identify gaps in service provision of GP services, but comments on this came out as a natural consequence of the study enquiry. Whilst South Asians had varying comments on their opinions of community pharmacy provision, comments also related to the provision of GP services. Most participants were very candid in discussing GP services. Participants illustrated that there were operational elements of GP services that needed to be addressed. This included access to GPs including the problems with GP appointments and GP receptionists being perceived as the 'guardians' to accessing GP services. Rashid and Jagger (1992) showed that South Asian patients reported finding it more difficult to gain access to their general

practitioners than non-Asian patients and relied heavily on accessing GPs for their health needs and that they preferred more 'personalised' care and continuity of care. South Asian participants and community pharmacists in this PhD study demonstrated clear frustrations about the perceived shortage of GPs and the unavailability of GP appointments at the time of the patients' choice. Automated telephone systems confounded the issue of access to GPs for people of non-English-speaking background. Access to GPs for 'emergencies' was found to be very difficult for South Asians. GP receptionists were identified to be 'unprofessional' in their attitude and because of this South Asians found this attitude to be particularly unhelpful led and trusting GP services. The findings of this study are also confirmed by Offredy (2002) and the evaluation commissioned by the Health Care Commission (Chisholm et al, 2004) by the Picker institute. Subsequent studies by Windridge et al (2004), Turner et al (2007) and Gerard et al (2008) show that patient preferences of seeing GPs of their choice and understanding their needs are still prevalent, and that management of appointments at GP surgeries should reflect these preferences.

Participants in this study wanted more time to be spent with them by GPs to discuss difficult and sensitive issues. Issues of privacy and confidentiality were important if pharmacists were to deliver new services and all participants welcomed the idea of private consultation area. Most participants commented that the pharmacists were not well informed of their health issues as they did not communicate well with the GPs. They underlined the fact that pharmacists had no access to their medical records and that this could lead to mixed messages and a feeling of confusion leading to mistrust. Other factors such as improving the pharmacist-patient relationship are also apparent from the findings as South Asians commented on the lack of engagement of pharmacists with them unless there was a particular problem with medicines on a prescription. It can be inferred from the findings that if more time was spent by the pharmacist at the 'front of their store' rather than 'at the back' (interpreted as in their dispensary as opposed to the front of their practice premises) they could improve the pharmacist-patient relationship. This could enhance trust and better understanding of the service users' healthcare needs. Whilst it is essential that professional advice is communicated in an appropriate manner, the findings also illustrate that the roles of all the members of pharmacy staff including counter assistants needs to be better promoted to South Asian service users so that patients know who they are speaking to and what professional roles they have. One South Asian participant commented that certain 'behaviours' such as referral to books during a consultation with a pharmacist could be interpreted as 'lack of the pharmacists' professional knowledge' if the reasons of such actions are not professionally communicated. In a study done in Pakistan, the author states

very clearly that patients in Pakistan would not regard their consultant / doctor as 'expert' if they were seen to check facts (Ahmad, 1992).

Some South Asians were clearly aware of the 'minimal' contact between GPs and community pharmacists. Examples of differences in the advice (particularly the issue of cost of antimalarial tablets) given for travel medicine from GPs and pharmacists have been illustrated in the findings and the lack of advice obtained when medicines 'changed colour' or 'looked different'. The findings also suggest that South Asians need explanation for changes, despite relying heavily on GPs ability to assure them of their health problems. Such services should be part of the pharmacists' standard contractual arrangements but there is a clear need for more structured information, and this could be better explained in a more detailed Medicines Use Review. The findings illustrated that GPs expected pharmacists to do the 'educational' elements of medicines use and that adequate time could be spent by the community pharmacist in doing so, and this finding adds to the need for such a service.

South Asian participants in this study also said that 'professional collaboration' was confined to 'communication' with regard to prescription queries. GPs and South Asian service users needed to understand that there is a radical 'shift' in some clinical responsibilities and be assured of the community pharmacists training and competence in their professional training and development. The findings of this study commend the promotion of the role of the community pharmacist to be an integral health care professional within the primary healthcare services in the NHS. Much more work and research needs to be done in this area, as recent reports illustrate that this radical shift is still not recognised by the medical profession (Bradley, 2009; Richardson and Pollock, 2010). There are still concerns raised about the lack of evidence of the value of new services, and the notion of commercial conflicts of interest. A recent report has been produced to encourage inter-professional collaboration between GPs and community pharmacists, highlighting their roles and responsibilities (BMA/NPA, 2009). The review by Darzi (2008) also emphasizes the importance of inter-professional working, and the findings of this PhD thesis illustrate the further need for such initiatives.

One of the GPs stated that that South Asians need to be better informed of the role of the NHS and appropriate use of NHS services, apart from the financial 'free' provision of services. The expectation of a service because it is 'free' needs to be addressed in its socio-economic context and is not 'cultural' or attributable to 'ethnic' needs (Kelleher, 1996). It can be further argued that in South Asia, health services are not 'free' and need to be purchased by the service users. Consultations with 'doctors' in South Asia include both 'western

orientated' and 'traditional' practitioners. Medicines provided by 'Pharmacists' in South Asia have to be purchased regardless of the ability of that person to pay. Social service provisions and infrastructure are also different in South Asia (Ahmad, 1992). The perception of 'free NHS services' and the drive to seek such services by South Asian service users needs to be explored further with healthcare professionals and service users from South Asian and indeed other ethnic backgrounds. There is a clear need to enhance knowledge of service users of the economies that underlie the service. Knowledge about cost of medication, cost of service and exactly how health care professionals who provide what appears to be a 'free' service needs to be made more transparent by publicizing that community pharmacists provide an 'NHS' service rather than one that is 'free'.

The concept of the service user as a 'purchaser' is more overtly evident in the community pharmacy setting where 'goods' are sold, including medicines. What may not be evident to the public is that in England, community pharmacists are 'providers' of an NHS commissioned service, similar to GP services and other NHS services such as certain dental services and optometry services, and that the NHS does remunerate those health care providers for such services. The notions of pharmacists being 'providers' of a 'free' service may then be more appropriately acknowledged and better utilized by this population. This is particularly important for the effective utilisation of community pharmacists in the new Pharmacy Contract, which will have the notion of 'advanced' and 'enhanced' services, where the aim is to streamline and improve access to health care. This may be one way to enable local NHS organisations to effectively promote the community pharmacists' role primarily as a health care professional in their own right where their services are contracted by the NHS at National level, similar to the GP contract. This has also been highlighted in the Pharmacy White paper (DH, 2000b) and the inference of the findings of this study is further confirmed by the increasing introduction of the use of the 'NHS' logo for community pharmacy premises<sup>17</sup>. Further research needs to be conducted to ascertain the value of such initiatives in improving the image of community pharmacies other than a 'retail premise' on the high street.

South Asian service users also mentioned 'tensions' in communication between the community pharmacist and the GPs. For example, some Moslem South Asian service users divulged that there were 'mixed messages' coming from pharmacists and GPs (particularly around the need for malaria medication and travel medicines) and that this could lead to

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<sup>17</sup> (2008: (<http://www.nhsidentity.nhs.uk/all-guidelines/guidelines/pharmacy/introduction> accessed Dec 2009).

confusion and non adherence to advice and suggested preventative medication. This was perceived by the South Asians to be 'insensitive', which confounded the 'professional' value of the relationship of South Asians with the GP. Such issues could also impede the South Asian's perceptions of understanding 'professionalism'. South Asians rely heavily on 're-assurance' for minor symptoms and conditions, but it can be argued that the same could be true for the white population, as shown in other studies (e.g. PAGB, 2009). If pharmacists work in isolation, and are perceived to rely on GPs for making decisions regarding patients' health and well being, they are and will continue to be regarded as 'subordinates' to the medical profession. The idea of 'subordination' has been discussed previously (see Chapter 5), and several studies in the literature have shown the need for better communication and cooperation locally between GPs and Pharmacists in order to improve the professional relationship between the two professions (examples include Spencer and Edwards, 1992; Bradley and Bond, 1995; Bradley et al, 1997, Bradley et al, 2008), more since re-iterated in the Pharmacy White Papers. Despite these findings and recommendations, the notion of improving inter-professional communication seems to be stagnant.

The findings of this PhD study are thus important in enhancing and understanding knowledge of what South Asians want community pharmacy services to offer as 'added value' and how such demands may be incorporated into future services and policies. There was an observed difference in the comments on consultation patterns between city centre pharmacies and those situated in high streets or community based environments, and this finding correlates well with the findings in the studies by Partop (1986), Jesson et al (1994b) and studies in the white population (Hammond et al, 2004). In her study, Hassell (2006) argues that there may be a difference between 'multiples' and 'independent' contractors and their approach to services, but differences in attitudes between pharmacists working in 'multiples' and 'independents' was not fully explored with South Asian participants. But there was an observed difference in the knowledge of between the pharmacists based in the City Centre (pharmacy participants 1 and 2) and those who were independents or locums (pharmacy participants 3, 4 and 5) about their local population needs. However, no significant judgement can be made from the findings of this PhD study. What is illustrated is the congruence of the interpretation of the findings from Phase 2 to what is argued by Cooper et al (2009) about pharmacists being regarded as 'sub-ordinates' to GPs, especially for the need of participants to be 're-assured' by GPs in the first instance and the portrayal of a 'consumerist' environment of the community pharmacy.

### ***Communication***

South Asians commented that interpreters were rarely used and there was a reliance on using family members and friends for interpreting. Participants tended to use pharmacies

where there were staff members who spoke their preferred language. Most participants preferred verbal information, and some commented that written information on medicine instructions was offered where appropriate. The findings of this study shows that new services would need to be culturally and appropriately targeted to the South Asian community using methods other than just translated leaflets and posters. The findings suggest the lack of an accessible 'repository' for health care professionals to access practical information regarding health promotion activities and medicines management initiatives for the local population. However, leaflets for communication were not liked by the participants as most of them could not read, write or speak English and there was a reliance on family members and friends when such information needed to be clarified. The findings within the theme of communication in this study align to the earlier reports by Johnson (1996, 1999) and in a subsequent report by Szczepura et al (2005) (see box 7, Chapter 3, page 123).

Leaflets for health promotion were rarely read unless they addressed specific issues that were important to the individual. Dissemination of health promotion and advice was further explored and all participants admitted that translated leaflets were rarely read, including younger participants in this study. More audio-visual methods were preferred, including television, peer education combined with other activities in a more community centred setting. The use of local media (radio and TV) may be appropriate but needs to be sustained to be effective. This can have tremendous resource implications. The value of translating every leaflet in other languages is questionable, especially if they are not going to be read or actively promoted (Jesson, 1998, Szczepura et al, 2005). The use and need of translated leaflets was not evident from the findings despite the literature findings suggesting otherwise. What is more apparent is that leaflets, let alone translated leaflets, were not used pro-actively by GPs or pharmacists with participants. Pharmacists were unaware of where to get translated information. South Asian participants did report that they rarely picked up information that was not of specific interest to them. It can be argued that if leaflets were pro-actively used, this may offer an opportunity for pharmacists to start developing a better pharmacist-patient relationship, not only on public health and self care issues, but also during counselling. The value of such a service has been illustrated by Anderson and Greene (1997) with the 'white' population. It may be that leaflets could be used as an active component of a pharmacy consultation as this will not only enhance knowledge, but also enhance communication with the South Asian service user. It can also be argued that adopting this method could also enhance the 'professional' role of pharmacists as an advocate for health promotion and public health advice as envisaged by the recent White Paper '*Choosing Health through Pharmacy*' (DH, 2005a).



Participants did not use telephone help lines, including NHS Direct and rarely used computers to access any health information. Very few South Asian service users had knowledge of this NHS Direct service. The findings of this PhD study add that there are other confounding issues (such as confidentiality) that need to be addressed for the South Asian population apart from accessing services where there are interpreters or those that offer advice by telephone. Access to information using information technology and multi-media touch screens may be useful for South Asian service users who are well versed with the use of this technology as demonstrated in the study by Jackson and Peters (2003, 2005) but should not be the only resource for this information. The findings of this PhD study showed that participants did not use IT to access health information. A further study by Goodyer et al (2006) was done to assess inhaler technique (for asthma) with participants who spoke Turkish as their first language as well as non-Turkish participants who were fluent in English. The study demonstrated that a translated leaflet, used alone, is of less benefit than the same leaflet used together with own-language verbal advice. The study by Goodyer et al (2006) also showed that the use of multi-media techniques could overcome the need for interpreters and that such methods of communication could be further explored in a community pharmacy setting. The researchers also found that participants who were fluent in English did not necessarily read leaflets and placed higher importance on face to face advice. This also supports the findings of this PhD study as well as the findings of the study by Jesson et al (1994b) and the report by Tuffnell et al (1994), who have concluded that it is simplistic to propose that written translation alone is the answer to the language barrier when providing medicines information to people whose first language is not English. However, it can also be further argued that the provision of leaflets as a primary mode of information is suitable for improving people's perceptions of health or medicines generally, and that 'hands on' provision of advice and education should be evaluated alongside other different modes of written and visual methods of health promotion and information. The findings of this study showed that it was the style of communication (using participants' own dialect) and building 'trust and rapport' that best enhanced meaningful engagement and communication with the South Asian participants.

Primary Care Trusts have been tasked to engage with community pharmacies to deliver some core national public health messages, as well as deliver locally identified health messages. The Pharmacy White paper for public health (DH, 2005a) clearly advocates the role for community pharmacists to deliver some of the components of the public health agenda and such services have been incorporated into the new Pharmacy contract in 2005. (DH, 2005d) The literature shows that there has been some research involving community pharmacy with public health campaigns, mainly targeted to the 'white' population (Anderson

et al, 2003a; 2003b, 2009). A review by Anderson (2007) has also confirmed that there are limitations in what community pharmacists are competent to deliver as far as health promotion and public health messages. The findings of this PhD study re-iterate that better awareness and knowledge of public health initiatives, particularly with the South Asian population, is needed in Leicester and that different methods to those used in the 'white' community can be integral to the success of this service. The new Pharmacy Contract does have 'health promotion' as a key essential service, and that the service specification goes beyond that of just 'display' of appropriate information. In addition, the service specification does include recognition of public health campaigns for dissemination through community pharmacies and for community pharmacists to pro-actively discuss public health issues, particularly for hard to reach communities (DH, 2005d). It is also specified within the contract that community pharmacists would need to record the advice given in the patients' medical record and that such data could be used in audit and evaluation. The author suggests that the outcomes of such campaigns, in particular of how this information raises further awareness and contributes to improvement of health outcomes of this population warrants further exploration, as the evaluation of the Pharmacy contract (Bond, Blenkinsopp et al (2007) are not encouraging.

*'Although many pharmacists report they were already doing 'campaign based healthy lifestyle promotion activities', 'prescription linked healthy lifestyle interventions' and 'signposting' prior to the new contract they may be referring to meeting the previous requirement to display leaflets rather than the interaction with patients and carers explicit in Community Pharmacy Contractual Framework.'* (Bond, Blenkinsopp et al (2007) page 30).

The findings of this study also show that health promotion activities for sensitive topics (e.g. sexual health, teenage pregnancy) need to be promoted and executed in a culturally appropriate manner. Health promotion initiatives in these specific health topics designed for the 'white' population may not work for the South Asian ethnic population. It would be unreasonable for PCTs to expect community pharmacies located in an area with a significant South Asian population to deliver a service which is not designed for uptake by a population. Pro-active promotion and use of publicity materials for such services may be perceived as a deterrent to using services. Literature also illustrates the pitfalls and benefits of using family members or patient advocates for this purpose in a consultation process. The use of 'informal' interpreters such as family members can be problematic when faced with embarrassing issues or when the informal interpreter's language skills are poor. Although

the study by Rashid and Jagger (1992) reported that the lack of knowledge of English was not a major problem for South Asian patients, subsequent studies have shown the contrary (Culley and Dyson, 2001 page 143; Johnson et al, 2004, Szczepura et al; 2005). This study shows that confidentiality is also an issue when discussing sensitive topics with South Asians. The use of family members as well as interpreters would be particularly controversial. GPs and pharmacists would need to ensure that South Asians were fully informed of the nature of the consultations and that they were given the choice of who they preferred for interpretation for medical and pharmacy consultations. In the focus group interviews, participants were segregated by religious group and gender in order to get further insights about their culture-specific perceptions of health beliefs and medicines. There were no significant differences between the different participant sets relating to religious beliefs, apart from the fast of Ramadan. However, it was noted during the study that the Sikh participants were the most subservient in their deliberations, and that participants in the Sikh focus groups included some very elderly participants who the researchers found challenging to engage. Szczepura et al (2005) suggest a possible explanation:

*'The messenger may be as importance as the message, and some potential messengers may not feel comfortable in that role, with particular 'audiences'. Messages must be specifically tailored to their audience, taking religious and other beliefs and practices into account. Information from official sources maybe of less impact unless fortified by personal experience and information from intra-community networks which establish a higher level of salience or 'emotional connectedness' with the issues being communicated. UK research and development is so far largely confined to descriptive, clinical, and exploratory work and does not yet include significant evaluation of interventions.'* (Szczepura et al 2005) Page 14)

'Targeted' approaches to health education were discussed with South Asian participants. What was evident was that health promotion through health fairs, 'meetings' and 'gatherings' at community centres would be beneficial, if done in ways to 'engage' members of the public. There is emerging evidence in the literature (e.g. Farooqi and Bhavsar, 2001) that local research and health education initiatives could be appropriately designed to harness the knowledge and expertise of members of their local communities. It is also inferred that the concept of community pharmacists to become 'social entrepreneurs' (Bissell et al, 2001; Ghalamkari and Jenkins, 2002) may be appropriate, working to develop the material and

social resources available to local communities. However, Bissell et al (2001) also conclude that the community pharmacists' ability to engage with local communities is restricted by their limited understanding of the link between social capital and health, and an unwillingness to be involved in such activities in the absence of remuneration. This was also found in a small exploratory study by Fenner et al (2004) in the majority white community. On the other hand, this PhD study did reveal a small number of South Asian service users who were positive about the engagement of community pharmacy with local community development issues / social capital. Within the South Asian culture, this is often seen as *sewa* or 'voluntary community/social work'. The findings of this PhD study also suggest that there needs to be better promotion of how the reconfiguration of pharmacy services could benefit this population, and the author of this study concurs with the challenges suggested in using appropriate 'social marketing' techniques (Jesson, 2007). The use of appropriate media and audio-visual aids could be considered for promoting the expertise of the pharmacist rather than the pharmacist 'selling' better health for 'profit'. For this PhD study, a considerable insight was also gained by talking to local community participants and community leaders, who could be 'champions' in promoting this role, bearing in mind the 'cultural' sensitivities' which have been highlighted in this PhD study. A few examples of how community pharmacy has engaged with South Asian service users have been reported as examples of good practice (personal communication, Green Light Pharmacy, Camden (2004); DH, 2004 (page 56)). Further research needs to be done to see how this could be better operationalised and indeed, if it can have meaningful health related outcomes for this population. Further pharmacy based initiatives by Gilani (2007, 2008), Huckerby et al (2006) and Howard et al (2007) also enhance this argument for pragmatic integration into day to day pharmacy services.

This PhD study considered some of the common issues that may affect clients of the South Asian minority ethnic community in Leicester City. However, it should be noted that these brief sketches of lay understandings can do little more than attune community pharmacists to the potential sources of influence on health behaviours. It is clear that for all groups, White British Christian people included, it is never simply a matter of 'having' a clear-cut, medically defined specific disease. All patients are active in making sense of their illness, for which they may draw upon lay health beliefs, alternative sources of healing, and different aspects of the medical model of the disease and its treatment. The blending of ideas from different belief systems is an achievement of the patient that may be carried out in different ways depending upon the particular context. 'Achievement' is important in this respect. The community pharmacist-patient encounter is one that is usually characterised as between a technical expert and a lay non-expert, possibly beset by a series of misconceptions.

However, these findings show that South Asian patients have to be very skilled indeed in assessing their own signs and symptoms and deciding whether or not to consult a community pharmacist. The reliance on the GP is still significant. They have a more 'exaggerated' response to minor symptoms that can cause anxiety; consult family members and friends; assess the impact of what is troubling them on their work and/or family commitments; make decisions about self-medication with home remedies, over-the-counter medicines or alternative treatments; optimising the use of their medicines and situating their experiences in relation to a religious world-view. Having executed this series of skilful decisions, and decided to consult a doctor, there were still differences in how participants responded to their particular circumstances, reluctantly, partially or not at all. How they achieve this 'transformation' to a more 'self managed' health seeking behaviour pattern, and the extent to which they achieve it, was varied within as well as *between* different ethnic groups in this study.

### **SECTION 6. 3.3 The strengths and limitations of the study findings**

This study was based largely on the views of six general practitioners, five community pharmacists and fifty five South Asian service users about the provision of community pharmacy services. The qualitative study methodology permitted a more in-depth view of how South Asians use community pharmacy services, enhanced by the views of three different participant groups. The findings of this PhD study confirm but add to the findings of the study conducted by Jesson et al (1994b).

The strength of the findings of this study stems from the views of the South Asian participants. Their knowledge of factors affecting their health and their understanding of their needs for a professional as well as 'human' nature of the community pharmacist was significant. Their candid revelations and reflections on professional relationships with community pharmacists provide a useful insight into the socio-pharmaceutical and 'cultural' aspects of improving their health and their understanding of medicines adherence.

The limitations of the findings include the paucity of data obtained from community pharmacists and GPs to enhance this debate, as 'saturation' of the data was not reached due to funding and time constraints of the study.

Although this study did not directly explore community pharmacists' direct knowledge of health inequalities and social determinants of their local population, the findings suggest that further understanding on how knowledge and understanding of specific cultural issues can inform better planning of community pharmacy services such as medicines use reviews, management of minor ailments and screening programmes.

#### ***Contribution of the research methodology to the study findings***

The study commenced in 2001, and then finally completed after a three year break in 2010. During this time there was a substantive and almost 'rapid' change in the government vision for community pharmacy services and the NHS. Despite major government policies, reviews and reports (since the Nuffield report in 1986) recognizing the importance of the contribution of community pharmacy services to the new NHS agenda, there was a paucity of evidence based research studies or evaluations involving community pharmacy service provision addressing diversity and local population needs. Whilst new and extra NHS services are commissioned in order to improve access to community pharmacists, there is a danger that evaluations of such initiatives are not designed to include interviews with service users and providers which could give significant insights into how such services are perceived and actually used. This PhD study demonstrated that qualitative social action research methods can and should be adopted in research strategies for evaluation of pharmacy services.

The findings of this study show that information collected through such methods can add value to data collected from standardized questionnaires such as those used by Jesson et al (1994b). By using the 'social action research model' (SARM) and culturally competent research assistants and community field workers, the qualitative research design and methodology of the current study allowed for the further exploration of issues that affect community pharmacy utilisation by the South Asian population.

Such research models have been used in many socio-medical studies. A key health worker with local knowledge of population characteristics, cultural needs and health beliefs was integral to the qualitative methodology adopted for this study, and the author's personal reflections of the research process have demonstrated this (Chapter 4). This study addressed an important and previously underexplored subject in pharmacy practice research. Many focus group participants included the least acculturated members of South Asian background. The 'cultural competence' of the field worker for the focus group interviews particularly for the Punjabi focus group was invaluable to this study. The significance of having culturally competent research associates has been acknowledged in major studies and reviews, many of which have been illustrated in Chapters 2 and 3. However, Bissell et al (2004) argue that it may not be necessary to match the ethnicity of the researcher and the researched community. In their study, Bissell et al (2004) interviewed people of Pakistani origin who did speak some English. Many participants in this PhD study did not speak or read English, and were more comfortable to speak in their own language through a community worker known to them. In addition, the principal investigator also accompanied the community worker to ensure fairness, and covered questions which 'missed' exploration of professional concerns and themes. Conversations flowed naturally and participants 'opened up' to 'probes' especially revealing their attitudes to sensitive topics. The interpretations of such issues in relation to pharmacy practice have been rarely reported in the pharmacy literature.

### **SECTION 6.3.4 How this research has changed my practice**

I believe the model I have suggested in this thesis is applicable to patients from all cultural backgrounds. Since this study was conducted, I have reflected on my personal practice and advocated several changes.

I advocate the concept of more pro-active communication and engagement with all service users and health care professionals. By reconfiguring pharmacy staff duties and responsibilities, I fully embrace the opportunity to communicate with service users by being available for them at the time when counselling on medicines is required as well as re-iterating key health promotion messages. Such practice is also applicable to other members of staff within the practice. By devolving certain duties to accredited pharmacy technicians, I am able to spend more time with all patients. Whilst this change in practice was also borne out by my experiences as a ward pharmacist in the hospital setting, this PhD study showed that this 'shift' from traditional working patterns was necessary in the community pharmacy setting.

I ask counter staff to identify patients who do not speak English and, with the patient's permission, note their ethnicity and preferred spoken language on their patient medication record. This helps me to promptly identify any potential problems in communicating and counselling with patients. Counter staff have also been trained to spend more time with patients to explain dosing instructions on medicines sold over the counter and to ensure patients' comprehension of the instructions, particularly for patients whose first language is not English. Counter staff not from a South Asian background discussed communication difficulties to appropriate staff members or signpost them to more appropriate services via Leicester City PCT. The use of NHS Direct is promoted provided patients have an understanding that they can request for interpreters.

Our pharmacy staff have been re-trained on local health issues and initiatives, supported by the PCT. Health promotion leaflets are pro-actively promoted and in many cases, important messages are verbally re-iterated. Members of staff have been informed of how to access and download appropriate translated leaflets and if necessary order them through appropriate sources, such as the NHS Choices website. This is only done on the patients request rather than through bulk orders as was the practice in the past.

I perform medication use reviews (MURS), a service which has been introduced as an 'advanced service' as part of the New Pharmacy Contract (2005). The current remuneration for this service is based on a 10-15 minutes consultation period. In my experience, I take



almost 40 to 60 minutes with patients on complex medication, particularly for those who do not speak English as their first language. The value of MURs is verbally re-iterated to service users, ensuring them of the confidentiality of the results. Where appropriate, patients can be accompanied by advocates or family members, with their permission. This can overcome initial communication barriers. I ask more 'open' questions during the consultation, as it has been my experience that patients were just 'agreeing' when asked about compliance. Since this study, asking more open questions has allowed more 'engagement' and patients appreciate that I take time to understand their 'difficulties' and thoughts without being patronising or judgemental. At the time of data collection, I picked up these soft skills through experiential work in GP surgeries, and I recognise that there is no other way that pharmacists can acquire these skills without having exposure to such practices. South Asians service users also appreciate an 'intervention' with their GP on their behalf and are fully aware of what the intervention comprises of. Although MURs are personally very satisfying from my own professional perspective, I would welcome more formal research on such initiatives, particularly with South Asian patients. Such studies should focus on communication issues, consultation outcomes and how this could impact on meeting local PCT targets for long term conditions such as coronary heart disease and diabetes which are prevalent in the South Asian population.

Since the study was conducted, I welcome the introduction of private consultation areas as a mandatory requirement for performing enhanced services. I perform many pharmacy consultations in a private area. Such consultations can be standard queries for symptoms as part of the standard contract, as well as part of enhanced service contract for minor ailments schemes. In my experience, such consultations are met favourably by **all** service users, including South Asian service users. Travel health and 'visiting friends and relatives abroad' initiatives have been reinforced, but the South Asian public generally are still wary of the cost of medication for malaria prophylaxis, particularly for endemic areas on the African sub-continent. A 'patient group directive' (PGD) for such medication would be a useful initiative in line with responding to the needs for this population.

The findings of this study acknowledge that this population benefits from a holistic approach to their health care needs. Through this study I have significantly updated my own knowledge of the policies underpinning the need for more flexible service delivery to members of this population. Through specific and sensitive questioning of patients, I am able to understand reasons for their health needs and understand some aspects of their health seeking behaviour.

However, I have reservations about whether GPs have the confidence to involve community pharmacists as part of a multidisciplinary decision making process. I acknowledge that this is not always possible due to the setting we work in as community pharmacists.

As a result of this study, I have fully embraced the importance of inter-professional collaboration and education. As a hospital pharmacist, multidisciplinary teamwork and inter-professional collaboration fall within the 'normal' remit of a modern hospital pharmacy practitioner. However, my practice as a community pharmacist did not encourage collaboration with GPs until the change in the New Pharmacy Contract. However, the lack of effective collaborative relationships in pharmacy practice settings is still apparent. I advocate the need for a more proactive approach to inter-professional education (IPE) and collaboration as part of continuous professional development within the practice setting. As pharmacists are being promoted as an accessible health care professional on the high street, it is important for pharmacists to embrace IPE as part of their professional development.

### **SECTION 6. 3.5 Recommendations for a minor ailments scheme for Leicester City**

This section describes how the findings from this study could be used to re-configure a local minor ailments enhanced service in Leicester City NHS Primary Care Trust. The author also describes how the research findings could have been used for a more substantive study that could compare the value of a community pharmacy led minor ailments service to that of a service in a GP setting.

At the time of this research study, the author was also involved in her capacity as a prescribing advisor with the introduction of a minor ailments scheme in Leicester City in 2003 supported by the National Medicines Management Collaborative, and by the National Prescribing Centre (NPC). The main driver for this scheme stemmed from the research conducted by Whittington et al (2001b). The main reason of the introduction of a minor ailments service in Leicester City was to improve access by service users to community pharmacists for 17 minor conditions. Service users were given the choice of whether they wanted to see the GP or the community pharmacist for the management of their symptoms. The drive for the service was to reduce the burden on already 'stretched' GP services. This would, in theory, help achieve 'access' targets, which the local PCTs had to demonstrate as part of their performance. A brief 'in house' evaluation of the local service illustrated that processes needed to be standardised and that training of community pharmacists was needed to update their knowledge of the management of symptoms. GPs indicated that communication processes needed to be more robust. The evaluation did show that that PCT access targets for GPs were being met and that the service could have contributed in meeting such targets. However, opinions about the value of such a service were contentious, and the project management team recommended that a substantive evaluation would be needed to demonstrate this.

The author also observed during her 'practice' sessions that South Asian service users appeared 'confused' by the processes of the service, and needed more time to understand the management of their symptoms. In her observations, she noted that patients appeared to use such schemes to just to obtain 'free' medicines. The data collected for this PhD study did not intentionally collect information that could be used to reconfigure the service, but the investigator acknowledges that the findings could be used in a pragmatic manner if the service was reconfigured.

The author would like to recommend that a minor ailments service would be of benefit to the population of Leicester City, provided that the service is designed to be 'fit for purpose'. Some the findings of this study underpin these suggestions.

The newly reconfigured Leicester City PCT commissioned the minor ailments service as a result of government initiatives for the reconfiguration of community pharmacy services and the recommendations within the Pharmacy White paper (DH, 2008). Results of brief evaluations of the former scheme were considered and the recommendations incorporated into the new scheme called 'Pharmacy First'. The author of this study took the initiative to do a comprehensive evaluation of other minor ailment schemes in different areas of the country, use the recommended toolkits as well as incorporate some major findings of this study into Pharmacy First, emphasising the need for effective communication with service users whose first language is not English. Collaboration with local general practitioners was important in service design. Effective promotion of community pharmacist as a health care professional was carefully considered to enhance the professional role of the community pharmacist. However, due to funding restraints, the promotion of these services could have been better executed using media and audiovisual aids.

Quality standards, monitoring and evaluation criteria were incorporated into the service. Whilst it can be argued that all these criteria are part of good practice, the author firmly believes that the findings of this study are validated and enhanced as a result of this exercise.

The scheme was successfully launched in November 2008 and is has undergone a rigorous evaluation using both quantitative methods and in depth qualitative interviews with GP practice staff, South Asian service users and community pharmacists (personal communication, Dr P Rivers, De Montfort University, Sept 2009). The outcomes of the evaluation have been favourable, allowing for further funding to continue the service. Box 17 illustrates some of the major processes within the service design, some of which have been influenced by the findings of this PhD study.

### **Box 17. Recommendations for the service components of a minor ailments scheme for NHS Leicester City Primary Care Trust 2008**

**Pharmacists must be trained and accredited to provide service.** PCT requirement for pharmacists to re-train and update knowledge about minor ailments. GPs made aware of pharmacists training. Specific training on consultation skills was provided and this was a mandatory requirement. The consultation for the minor ailment needs to be done by the pharmacist. Many other similar schemes in England do not have this as a mandatory requirement, resulting in counter assistants conducting the consultation. It was hoped that this would raise the profile of the pharmacist as a health advisor

**For this scheme, all consultations for a minor ailment must be done in a private consultation area.** The results of this study enhance this recommendation. Patients who cannot speak English are invited to bring advocates of their choice or ask the pharmacist to use counter staff who speak the language during consultation. Consent for this is obtained from patients. This is incorporated into the service level agreement

**The use of standardised information leaflets in English (via NHS Direct) about the condition together with verbal explanations of important points in leaflets, particularly for service users whose first language is not English.** Translated leaflets have **not** been produced for this service.

**The mandatory capture of information on ethnicity on the consultation form for evaluation purposes.** As a result of the study findings

**The issue of a standard consultation form capturing the advice given and medicines dispensed to the service user.** A document is produced as part of the consultation process. A copy of this is given to the patient for their information, with a further copy for referral to the GP. This enhances communication between community pharmacists and GPs, and re-assures the GP and the patients of the outcomes of referrals. Patients are verbally assured that they can be referred back to the GP by the community pharmacist if the symptom warrants a physician's intervention. Community pharmacists can also refer patients directly to A&E departments. This enhances professionalism and trust in the community pharmacy consultation

**Appropriate advice on the medicines supplied.** This included an explanation of the use of 'generic' medicines from an agreed 'list' of products. If these were not acceptable, the patients were offered the choice of purchasing a branded product.

**Recommendations for an appropriate evaluation of the study.** Appropriate recommendations have been made to capture service user acceptance of the scheme, patient satisfaction, GP appraisal and community pharmacist satisfaction. This includes recommendations from qualitative and quantitative methods, and interviews with patients in their own dialect. \*(Note: the evaluation has been done in 2010).

**Recommendation for effective promotion of the scheme to all GPs, health care professionals and social service providers in Leicester City, including community centres and places of worship.**

The service was effectively promoted through GP Forums and patient and public forum meetings, a combination of poster, media services and community events, including South Asian Radio and television channels.

**Multi-disciplinary input in the design of the scheme.** Two local GPs, two nurses and service user representatives were closely involved in the design of the service. Robust protocols were produced in collaboration with the GPs and underpinned by clinical governance arrangements ensuring confidentiality. This enhanced inter-professional collaboration.

**Limit on the number of consultations for the same condition in a given period.**

Patient consultations can be 'tracked' ensuring that patients can be appropriately referred back or signposted to other services if necessary. This also ensured that service is not used to 'stockpile' medicines.

### SECTION 6.3.6 Recommendations for further professional development, education and research

The recommendations made by Jesson et al (1994b) are still current and valid as demonstrated by the findings of this PhD study. Additional comments and recommendations newly arising from this more recent investigation include the following:

1. Pharmacists and pharmacy staff should consider engaging in CPD activities to provide a more 'culturally competent' service. Such development and learning opportunities should include the understanding of the importance of use of appropriate 'consultation' skills in order to build 'rapport and trust' with **all** service users. The learning skills should include:

- Understanding the disparities in the health of their local population
- Avoiding harmful 'stereotyping' by recognising that **every** patient has **unique** needs that are based on factors such as their own health status, ability to communicate, race, ethnicity, culture and socioeconomic status
- Acknowledging that 'culture' helps determine patient beliefs about health and illness, including different ways patients express their symptoms (or not as the case might be), how patients interpret their symptoms and how they use healthcare services to alleviate these symptoms
- How to tailor a pharmaceutical care plan to fit a specific patient need based on the patients cultural beliefs and understanding of their health
- Reflection on cultural differences and communication techniques in a way the patient will best understand and engage with pharmacists and their staff
- Assuring patients of collaboration knowledge of other health and social services, including GPs

2. Standard operating procedures within community pharmacies should recommend the voluntary capture of ethnicity and religion into the patients' medical record, with patients' permission. This could potentially help with further research initiatives with adherence, health promotion activities and help community pharmacists to have a more individually 'targeted approach' to healthcare delivery.

3. Healthcare professionals delivering such services would need to be more aware of the 'stigmas' relating to their population groups. A more 'appropriate' environment to discuss sensitive issues could be considered. This could include the use of a private consultation area or a quiet area of the pharmacy. All service users should be offered the chance to discuss such issues irrespective of health or cultural status

4. Health promotion activities for sensitive topics (e.g sexual health, teenage pregnancy) need to be promoted, 'marketed' and executed in a culturally appropriate manner, with the collaboration of local communities.

5. The use of audio-visual interventions in various languages could be further explored to overcome the need for interpreters particularly in the community pharmacy setting.

6. Verbal re-enforcement of messages relating to health promotion campaigns was suggested by service users, preferably in their first language. Pharmacists need to be 'flexible' to do such activities in community settings if their contractual arrangements were more accommodating.

7. Both GPs and pharmacists need a common 'collaborative' approach about enabling effective medicines adherence in a medication use review. 'Open' questioning to establish health beliefs in the first instance may allow

- Exploration of medicines use during the fast of Ramadan, and recognising that there are 'caveats' about medicines use during this period. This guidance needs to be appropriately verified by the local community leaders so that the advice is unilateral and equivocal across all health care settings
- Clinically significant drug interactions (if any) with herbal medicines that are commonly used by this population
- Exploration of medication adherence when patients go abroad, and re-enforcing messages through appropriate education and review.
- Ascertain understanding of patients views when there are changes to their medicines, including generic substitution
- Deeper exploration of 'somatic' symptoms (ideal opportunity for consultations for minor ailments)

8. More effort is needed to raise awareness of where to obtain appropriate health promotion resources that are easy to understand and read. 'Translated' information is not always necessary. Information could be available electronically, such that pharmacies could access these and use them pro-actively where necessary. Examples of such leaflets could include information specific to NHS services and operations, and 'standardised' information about the management of health conditions. It has been noted that since data collection for this study the website NHS Choices<sup>18</sup> has been launched for access to information about various

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<sup>18</sup> (<http://www.nhs.uk/aboutNHSChoices/aboutnhschoices/Aboutus/Pages/languageshub.aspx> accessed Sept 2010)

NHS topics, including information in other languages. In the author's professional opinion, community pharmacists need to be more aware of the availability of such resources and include the resource in their standard operating procedures.

9. The author would like to recommend that the undergraduate pharmacy curriculum incorporates the teaching of health inequalities, disparities, diversity and 'cultural competence' and the pragmatic application of social-behavioural sciences in relation to both individuals and populations

10. The study can be repeated to include interviews with nurses, and other South Asian populations such as the Bengali population. A strong recommendation to repeat the study with the 'white' population, with a focus on cultural behavior patterns and deeper exploration of health beliefs and health behavior relating to medicines use. Research strategies could include explorations of 'responsiveness' to patients by community pharmacists and their staff, and whether changes in community pharmacy practice delivery improve medicines adherence and health outcomes. Such research initiatives should include 'action research' methodologies.



# Chapter 7

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## **Conclusion**

## CHAPTER 7. CONCLUSION

*Any patient, black or white, will have a particular culture, ethnicity, education, socio-economic background, health beliefs and experiences. In particular, there is a need for pharmacists to recognise and be sensitive to these issues. Successful public health initiatives and pharmaceutical care requires that we understand the lifestyle, beliefs, attitudes, and family and social networks of the patients being treated. (adapted from Greenhalgh et al, 1988 – ‘clinical’ focus replaced by ‘pharmacy’ focus.)*

This thesis began from an understanding encapsulated in Greenhalgh’s comments – which have been adapted from a more general primary care clinicians’ perspective to highlight their applicability to pharmacy practice. It therefore set out to explore the following questions:

- What factors affect the use of community pharmacy services by the South Asian population in Leicester City?
- Are community pharmacists meeting the needs of service users from the South Asian minority ethnic population for the provision of health advice and pharmaceutical care, particularly for the management of minor ailments?

Following an initial literature review and discussion with members of the research supervision team, these aims were formalised as follows:

### RESEARCH AIMS

To explore the following areas:

- Perceptions of the current pharmacy services by members of the local South Asian ethnic population and local GPs
- GPs and pharmacists’ knowledge of cultural sensitivities (if any) relating to the use of medicines by the local South Asian ethnic population.
- Barriers and incentives for the ‘new’ extended community pharmacy services from local GPs, community pharmacies and members of the local South Asian ethnic minority population

## INTENDED OUTCOMES

- identify cultural beliefs that influence a GP consultation process and the role of the community pharmacist
- identify patient education and patient health information needs of members of the S Asian ethnic minorities
- highlight methods to improve communication process between pharmacists , GPs and members of this community
- ascertain barriers and/or opportunities (if any) for future community service initiatives in improving the health of this population, particularly relating to the management of minor ailments and medicines adherence

The author of this study firmly believes that the outcomes of this study have been met. Many of the findings of the study still concur with the study by Jesson et al (1994b), which was published almost 17 years prior to completion of this thesis. This study, conducted in Leicester City, has found similarities to and endorses findings of the study by Jesson et al (1994b) conducted in Birmingham. This PhD study has also contributed to the existing body of knowledge in a number of ways.

**Main contributions** (distinguishing from previous work) include the following:

The SARM methodology used in this study allowed further exploration of the cultural and sociological aspects of behaviour and the impact of 'cultural' influences on medicines adherence. South Asian people's understanding of what affects their health and medicines adherence can also be interpreted in terms of 'stress', fate and 'karma' and although these factors cannot be solely attributable to a South Asian 'culture', they should be explored with **all** individuals. As far as can be ascertained, such a methodology has not been used in pharmacy mainstream research before, and it is hoped that this will demonstrate and encourage its future application in the discipline.

The findings revealed that South Asians rarely discuss sensitive or stigmatised issues with community pharmacists in the same way as a 'white' population does. This can have future implications for the promotion and uptake of some 'newer' enhanced services, such as the supply of emergency hormonal contraception and sexual health screening services. Whilst it is acknowledged that these issues might also be 'sensitive' to the 'majority' population, it is important to note that notions of stigma in the South Asian population extend beyond these topics, to other conditions such as asthma and impact of sexual health screening (e.g. for

Chlamydia) on infertility. Such issues can be perceived to have negative impact on the 'social acceptance' of South Asian individuals with such conditions within their own communities, and will need more culturally sensitive communication and health promotion methods.

South Asians pro-actively engaged with community based approaches, and an opportunity for community pharmacists to become involved with such initiatives was inferred from the findings. Examples illustrated include initiatives such as a negotiated understanding of exercise as part of weight management, further insight into the understanding of the Fast of Ramadan, the use of 'paan' and its consequences on oral cancer and the importance of collaboration between health care professionals and community leaders in promoting medicines adherence.

Factors affecting non adherence to medicines cannot be generalised or be attributed to the wide 'umbrella' concept of 'culture' as the only argument for 'specialist' services for minority ethnic populations. However, the findings illustrate the need for all pharmacists to be 'culturally knowledgeable and competent' about the communities in which they practice, in order to provide meaningful, pro-active and more responsive services to their local population. In particular, the findings show that South Asians adherence to medicines may be affected particularly whilst on holiday to their homeland, where external influences such as the weather and alternative healthcare practices were shown to affect medicines adherence. Many South Asian participants in the study also had limited understanding about 'generic' medicines and considered these to be 'inferior' or 'less effective' than 'branded' medication. The notion of 'sharing' of medicines was also illustrated. Such findings highlight the need for the Medicines Use Review (MUR) service, including a more 'targeted' exploration of medicines adherence and medicines optimisation, additional to the processes stipulated in the service specification within the Pharmacy Contract. It is suggested that more 'open' interview questions and appropriate consultation skills would be needed to explore the health beliefs held by this population, compared to traditional 'reactive' communication styles that are still prevalent in community pharmacy.

By harnessing this knowledge, community pharmacists and their staff could be developed and trained to deliver a more targeted service which has a greater chance of having a meaningful and positive impact on health outcomes in this population, by spending adequate time with patients and developing a patient-practitioner relationship that promotes trust.

There are some other findings which are not unique to this study, but add valuable and additional insight to existing knowledge and literature.

South Asians welcomed the introduction of minor ailments schemes in order to obtain medication which would otherwise require an appointment to see a GP. However, unless community pharmacists can be seen to 'diagnose' it is unlikely that they will be seen as the first port of call for this community for advice on the management of minor ailments unless the role of the pharmacist as an autonomous health care professional in their own right is highlighted, as opposed to the 'shopkeeper' image currently perceived. This finding may not be unique to just the South Asian population, and warrants further consideration for a more pragmatic action research initiative. South Asians rely heavily on the GP for a 'diagnosis'. GPs reinforced existing research evidence that this population tends to consult for somatic overt symptoms, and that they consult less frequently for the management of long term conditions which may not necessarily manifest in overt symptoms.

The findings have illustrated that, despite changes in pharmacy policies, there seems to be little change in observed practice since the recommendations of the Nuffield Enquiry in 1986. The lack of inter-professional collaboration between community pharmacists and GPs noted is not a new observation, but although this is changing to some extent, it is still nowhere near to achieving the NHS policy goals of multidisciplinary collaboration and care in order to improve patient outcomes. Community pharmacists are still perceived to have a 'subordinate' status to GPs, and this is observed in the findings of this study as it describes the beliefs of South Asian participants.

There is limited evidence-based pharmacy practice research on the impact of current or re-configured pharmacy services and this is not just unique to the South Asian population. Research studies underpinning the major policies are sparse. Only a few of the pharmacy studies cited in this thesis utilised robust methodologies. More studies are needed that evaluate patient outcomes and demonstrate cost effectiveness.

In conclusion, it may be observed that this study has replicated, in a pharmacy setting, the findings of the community-based Afiya trust in relation to carer support:

*Needs are universal; solutions may be different. People and carers from BME communities mostly have the same needs as others. However, culturally sensitive ways of enabling people to access services are needed, and some services may need to adapt the way they are provided to meet the needs of particular communities. Different communities are likely to require different approaches to meet the same needs (from the report 'Beyond We Care Too: Putting Black Carers in the Picture'. Afiya Trust and National Black Carers & Carers Workers Network, 2008. Reproduced with permission.)*

# References

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## REFERENCES

- AADIL, N., HOUTI, I. & MOUSSAMIH, S. (2004) Drug intake during Ramadan. *BMJ*, 329, 778-82.
- ABBAS, S. JAIN, A., RUMBLE, R., MORGAN, K., & ASLAM, M. (1992) Drug utilization among elderly Asian women. *The Pharmaceutical Journal (Pharmacy Practice Research supplement)*, 249.
- ABU-OMAR, S. M., WEISS, M. C. & HASSELL, K. (2000) Pharmacists and their customers: personal or anonymous service? *International Journal of Pharmacy Practice*, 8, 135-143.
- ACHESON, D. (1998) Independent inquiry into inequalities in health: Report. London, Department of Health.
- ACKROYD, R. (2003) Audit of referrals to a hospital palliative care team: role of the bilingual health-care worker. *International Journal of Palliative Nursing*, 9, 352-357.
- AFIYA TRUST and NBCCWN (2008). Beyond We Care. Putting Black carers in the Picture. Published by the Afiya Trust, London.
- AHMAD, F., CAMERON, J. & STEWART, D. (2005) A tailored intervention to promote breast cancer screening among South Asian immigrant women. *Social Science & Medicine*, 60, 575-586.
- AHMAD WIU, KERNOHAN E, BAKER M (1989). Patients' choice of general practitioner: influence of patients' fluency in English and the ethnicity and sex of the doctor. *J R Coll Gen Pract*, ;39:153-5.
- AHMAD, WIU. , BAKER, M. & KERNOHAN, E. (1990) Race, ethnicity and general practice. *Br J Gen Pract*, 40, 223-4.
- AHMAD, W. I., KERNOHAN, E. E. & BAKER, M. R. (1991) Patients' choice of general practitioner: importance of patients' and doctors' sex and ethnicity. *Br J Gen Pract*, 41, 330-1.
- AHMAD, W. I. U (1992). The maligned healer: the hakim and western medicine. *New Community* 18,4 :521-536
- AHMAD, W.I.U (1993). Making black people sick: ``race'', ideology and health research. In: Ahmad W, editor. Race and health in contemporary Britain. Buckingham: Open University Press.
- AHMAD, WIU (1996). The trouble with culture. In Kelleher, D and Hillier, S (eds). *Researching cultural differences in health*. London: Routledge.
- AKHTAR, S. (2001) Fasting during Ramadan: a Muslim pharmacist's perspective. *The Pharmaceutical Journal*, 267, 691-2.
- AL SUWAIDI, J., BENER, A., SULIMAN, A., HAJAR, R., SALAM, A. M., NUMAN, M. T. & AL BINALI, H. A. (2004) A population based study of Ramadan fasting and acute coronary syndromes. *Heart*, 90, 695-6.
- ALEXANDER, Z. (1999) Study of Black, Asian and Ethnic Minority Issues. . Department of Health. London,

ALI, N. & HUSSAIN-GAMBLES, M. (2005) Complementary and alternative medicine (CAM) use among South Asian patients with cancer in Britain *Diversity in Health and Social Care*, 2, 41-46.

ALI, N., ATKIN, K. & NEAL, R. (2006). The role of culture in the general practice consultation process. *Ethn Health*, 11, 389-408.

ALL PARTY PARLIAMENTARY GROUP (2008) Inquiry Report on GP access and health Improvement in Primary Care. London,  
<http://www.pagb.co.uk/information/PDFs/finalinquiryreport.pdf> (accessed Dec 2009).

AMBLER, S. (2003) General practitioners and community pharmacists: times they are a-changing. *The British Journal of General Practice: The Journal of The Royal College Of General Practitioners*, 53, 594-595.

AMERICAN PHARMACEUTICAL ASSOCIATION TASK FORCE (2000) White Paper on Pharmacy Student Professionalism. *Journal of the American Pharmaceutical Association*, 40, 96-102.

ANDERSON, C. (1998) Health promotion by community pharmacists: consumers' views. *International Journal of Pharmacy Practice*, 6, 2-12.

ANDERSON, C. (2000) Health promotion in community pharmacy: the UK situation. *Patient Educ Couns*, 39, 285-91.

ANDERSON, C., BLENKINSOPP, A. & ARMSTRONG, M. (2003a) Report 1: The contribution of community pharmacy to improving the public's health: Evidence from the peer-reviewed literature 1990-2001. PharmacyHealthLink (formerly known as the Pharmacy Healthcare Scheme) and the Royal Pharmaceutical Society of Great Britain.  
<http://www.pharmacyhealthlink.org.uk/files/Evidence%20Base%20Report%201.pdf>  
(accessed Dec 2009)

ANDERSON, C., BLENKINSOPP, A. & ARMSTRONG, M. (2003b). Report 2: The contribution of community pharmacy to improving the public's health: Evidence from the non peer-reviewed literature 1990-2002. PharmacyHealthLink (formerly known as the Pharmacy Healthcare Scheme) and the Royal Pharmaceutical Society of Great Britain.  
<http://www.pharmacyhealthlink.org.uk/files/Evidence%20Base%20Report%202.pdf>  
(accessed Dec 2009)

ANDERSON, C. & BISSELL, P. (2004a) Using semi covert research to evaluate an emergency hormonal contraception service. *Pharm World Sci*, 26, 102-6.

ANDERSON, C., BLENKINSOPP, A. & ARMSTRONG, M. (2004b) Feedback from community pharmacy users on the contribution of community pharmacy to improving the public's health: a systematic review of the peer reviewed and non-peer reviewed literature 1990-2002. *Health Expect*, 7, 191-202.

ANDERSON, C., BLENKINSOPP, A. & ARMSTRONG, M. (2009). The contribution of community pharmacy to improving the public's health: Summary report of the literature review 1990-2007. *PharmacyHealthLink*.

ANDERSON, C. & GREENE, R. (1997) Barnet High Street Health Scheme: health promotion by community pharmacists. *Pharmaceutical Journal*, 259, 223-225.



- ANDERSON, S. (2007) Community pharmacy and public health in Great Britain, 1936 to 2006: how a phoenix rose from the ashes. *J Epidemiol Community Health*, 61, 844-8.
- ANNANDALE, E. (1997). The sociology of health and medicine. A critical introduction. Cambridge, Polity.
- ASLAM, M. (1979). The Practice of Asian Medicine in the United Kingdom, PhD thesis, University of Nottingham.
- ASLAM, M. & SHAW, J. (1992a) Problems of identity with traditional Asian remedies. *The Pharmaceutical Journal*, 248, 20-23.
- ASLAM, M. & WILSON, J. (1997) Pharmacists, medicines and the fast of Ramadan. *The Pharmaceutical Journal*, 259, 973-975.
- ASLAM, M. & WILSON, J. (1992b) Medicines, health and the fast of Ramadan. *J R Soc Health*, 112, 135-6.
- ASPINALL, P. & JACOBSON, B. (2004) Ethnic Disparities in Health and Health Care: A focused review of the evidence and selected examples of good practice. London Health Observatory
- ASPINALL, P. J. & JACOBSON, B. (2007). Why poor quality of ethnicity data should not preclude its use for identifying disparities in health and healthcare. *Quality and Safety in Health Care*, 16, 176-180.
- ASSOCIATION OF PUBLIC HEALTH OBSERVATORIES (APHO) 2005. Indications of Public Health in the English Regions 4: Ethnicity and Health. <http://www.apho.org.uk/resource/item.aspx?RID=39367> (accessed Dec 2009)
- ATKIN, K. (1996) 'An opportunity for change: the voluntary sector provision in a mixed economy of care', in Ahmad, W. and Atkin, K. *Race and Community Care*. Cambridge: Open University
- ATKINSON, R and FLINT, J (2001). Accessing Hidden and Hard-to-Reach Populations: Snowball Research Strategies. Social Research Update, Issue 33 (University of Surrey)
- ATKINSON, M., CLARK, M., CLAY, D., JOHNSON, M. R. D., OWEN, D. & SZCZEPURA, A. (2001) Systematic Review of Ethnicity and Health Service Access for London. Centre for Health Services Studies, University of Warwick, Coventry, UK.
- ATRI, J., FALSHAW, M., GREGG, R., ROBSON, J., OMAR, R. Z. & DIXON, S. (1997) Improving uptake of breast screening in multiethnic populations: a randomised controlled trial using practice reception staff to contact non-attenders. *BMJ*, 315, 1356-1359.
- AUDIT COMMISSION (1994). Audit Commission. What seems to be the matter: Communication between hospitals and patients. Audit Commission report. London: HMSO, 1994.
- BALARAJAN. R. (1996). Ethnicity and Health in England. Department of Health. Stationery office. London.
- BANDESHA, G. & LITVA, A. (2005) Perceptions of community participation and health gain in a community project for the South Asian population: a qualitative study. *Journal of Public Health*, 27, 241-245.

BANISTER, P., BURMAN, E., PARKER, I., TAYLOR, M. AND TINDALL, C. (1994). *Qualitative methods in psychology: a research guide*. Buckingham; Open University Press. Chapter 1

BARBER N, PARSONS J, CLIFFORD S, DARRACOTT R AND HORNE R. (2004). Patients' problems with new medication for chronic conditions *Qual Saf Health Care*; **13**:172-175

BARBOUR, R. S. (2001) Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *BMJ*, 322, 1115-1117.

BARNES, J. (2003) Quality, efficacy and safety of complementary medicines: fashions, facts and the future. Part II: Efficacy and safety. *British Journal of Clinical Pharmacology*, 55, 331-340.

BARR, H. (1998) Competent to collaborate: Towards a competency-based model for interprofessional education. *Journal of Interprofessional Care*, 12, 181-187.

BEISHON, S. & NAZROO, J. (1997) Coronary heart disease: contrasting the health beliefs and behaviours of South Asian communities. London, Health Education Authority.

BELL, H., MCELNAY, J. & HUGHES, C. (2000). Societal perspectives on the role of the community pharmacist and community based pharmaceutical services. *Journal of Social & Administrative Pharmacy*, 17, 119-128.

BENAJI, B., MOUNIB, N., ROKY, R., AADIL, N., HOUTI, I. E., MOUSSAMIH, S., MALIKI, S., GRESSIER, B. & EL GHOMARI, H. (2006) Diabetes and Ramadan: review of the literature. *Diabetes Res Clin Pract*, 73, 117-25.

BENEY, J., BERO, L. A. & BOND, C. (2000). Expanding the roles of outpatient pharmacists: effects on health services utilisation, costs, and patient outcomes. *Cochrane Database Syst Rev*, CD000336.

BENSON, A., CRIBB, A. & BARBER, N. (2007) Respect for medicines and respect for people: mapping pharmacist practitioners' perceptions and experiences of ethics and values. London, Report for The Royal Pharmaceutical Society of Great Britain

BENTLEY, P., JOVANOVIC, A. & SHARMA, P. (2008) Cultural diversity training for UK healthcare professionals: a comprehensive nationwide cross-sectional survey. *Clinical Medicine*, 8, 493-497.

BHACHU, P. (1985). *Twice Migrants: East African Sikh Settlers in Britain*. Tavistock Publications (London)

BHATNAGAR, D., ANAND, I. S., DURRINGTON, P. N., PATEL, D. J., WANDER, G. S., MACKNESS, M. I., CREED, F., TOMENSON, B., CHANDRASHEKHAR, Y., WINTERBOTHAM, M. & ET AL. (1995) Coronary risk factors in people from the Indian subcontinent living in west London and their siblings in India. *Lancet*, 345, 405-9.

BHATT, A. & DICKINSON, R. (1992). An analysis of health education materials for minority communities by cultural and linguistic group. *Health Education Journal*, 51, 72-77.

BHOPAL, R. (1997). Is research into ethnicity and health racist, unsound, or important science? *BMJ*, 314: 1751

BHOPAL, R. & DONALDSON, L. (1998) White, European, Western, Caucasian, or what? Inappropriate labelling in research on race, ethnicity, and health. *Am J Public Health*, 88, 1303-1307.

BHOPAL, R., VARTIANEN, E., FISCHBACHER, C., UNWIN, N., WHITE, M. & ALBERTI, G. (2004) Cardiovascular risk factors, predicted risk of outcomes, and observed mortality in South Asian populations. *Ethn Health*, 9, S59-S60.

BHOPAL, R., WILD, S., KAI, J. & GILL, P. S. (2009) Health Care Needs Assessment: Black and Minority ethnic Groups. The Epidemiologically Based needs Assessment reviews. Publisher: Health care needs assessment  
([http://www.hcna.bham.ac.uk/documents/04\\_HCNA3\\_D4.pdf](http://www.hcna.bham.ac.uk/documents/04_HCNA3_D4.pdf) accessed Jan 2010)

BHOPAL, R. S. (1986). The inter-relationship of folk, traditional and Western medicine within an Asian community in Britain. *Social Science & Medicine*, 22, 99-105.

BHUGRA, D. & HICKS, M. H.R. (2004) Effect of an Educational Pamphlet on Help-Seeking Attitudes for Depression Among British South Asian Women. *Psychiatr Serv*, 55, 827-829.

BHUI, K. (1998) Breaking down language barriers. The public favours bilingual staff over interpreters. *BMJ*, 317, 817.

BISSELL, P., WARD, P. R. & NOYCE, P. R. (1997). Variation within community pharmacy. Part 2. Responding to the presentation of symptoms. *Journal of Social & Administrative Pharmacy*, 14, 105-115.

BISSELL, P., WARD, P. R. & NOYCE, P. R. (2000). Mapping the contours of risk: consumer perceptions of non-prescription medicines. *Journal of Social & Administrative Pharmacy*, 17, 136-142.

BISSELL P, ANDERSON C & BLENKINSOPP A. (2001). Has community pharmacy a role in dealing with health inequalities? *Pharmaceutical Journal*; 267: 880

BISSELL, P., MORGALL TRAUSLEN, J. & HAUGBOLLE, L. (2002a). Sociological Theory and Pharmacy Practice Research: (4) The contribution of interactionist sociology to understanding the experience of health and illness. *International Journal of Pharmacy Practice*; 10 (3): 213–224, September

BISSELL, P. & JESSON, J. (2002b) Health Inequalities- a neglected area of pharmacy policy and practice. *The Pharmaceutical Journal*, 269, 819-821.

BISSELL, P. & ANDERSON, C. (2003a) Supplying emergency contraception via community pharmacies in the UK: reflections on the experiences of users and providers. *Social Science & Medicine*, 57, 2367-78.

BISSELL, P., MORGALL TRAUSLEN, J. & HAUGBOLLE, L. (2003b) Researching 'race', ethnicity and health: a critical review. *International Journal of Pharmacy Practice*, 11, 183-197.

BISSELL, P., MAY, C. R. & NOYCE, P. R. (2004). From compliance to concordance: barriers to accomplishing a re-framed model of health care interactions. *Social Science & Medicine*, 58, 851-862.

BISSELL, P. & ANDERSON, C. (2005) Enhanced access to emergency contraception. *Lancet*, 365, 1668-70.

BISSELL, P and MORGALL-TRAULSEN, J (2005). *Sociology and Pharmacy Practice*, London. Pharmaceutical Press

BISSELL, P. (2006a) Social Capital and Community Pharmacy: A Critical Review. *European Journal of Social Quality*, 6, 109-119.

BISSELL, P., RYAN, K. & MORECROFT, C. (2006b) Narratives about illness and medication: a neglected theme/new methodology within pharmacy practice research. Part I: conceptual framework. *Pharm World Sci*, 28, 54-60.

BISSELL, P., SAVAGE, I. & ANDERSON, C. (2006c). A qualitative study of pharmacists' perspectives on the supply of emergency hormonal contraception via patient group direction in the UK. *Contraception*, 73, 265-70.

BISSELL, P., BLENKINSOPP, A., SHORT, D. & MASON, L. (2008). Patients' experiences of a community pharmacy-led medicines management service. *Health Soc Care Community*, 16, 363-9.

BLACK, D. (1980). *Report of the Working Group on Inequalities in Health* (Chair: Sir Douglas Black) London: Department of Health & Social Security.

BLAKEMORE, K. (2000) Health and social care needs in minority communities: an over-problematized issue? *Health Soc Care Community*, 8, 22-30.

BLENKINSOPP, A., BOND, C., CELINO, G., INCH, J. & GRAY, N. (2007). National evaluation of the new community pharmacy contract. London, Pharmacy Practice Research Trust, Royal Pharmaceutical Society.  
[http://www.pppt.org.uk/Documents/Publications/National\\_evaluation\\_of\\_the\\_new\\_pharmacy\\_contract.pdf](http://www.pppt.org.uk/Documents/Publications/National_evaluation_of_the_new_pharmacy_contract.pdf) (accessed Dec 2008)

BLENKINSOPP, A. & BRADLEY, C. (1996). Patients, society, and the increase in self medication. *BMJ*, 312, 629-32.

BLENKINSOPP, A. & NOYCE, P. R. (2002) Minor illness management in Primary care: a review of community pharmacy NHS schemes Keele University, Department of medicines management.

BLENKINSOPP, A., ANDERSON, C. & ARMSTRONG, M. (2003). Systematic review of the effectiveness of community pharmacy-based interventions to reduce risk behaviours and risk factors for coronary heart disease. *J Public Health Med*, 25, 144-53.

BLENKINSOPP, A. AND BOND, C. (2007). Pharmacists must learn to play their part in multi-disciplinary teams. *The Pharmaceutical Journal*, 279: 330-332

BOARDMAN, H., LEWIS, M., CROFT, P., TRINDER, P. & RAJARATNAM, G. (2005) Use of community pharmacies: a population-based survey. *J Public Health*, 27, 254-262.

BOJKE, C., GRAVELLE, H., HASSELL, K. & WHITTINGTON, Z. (2004) Increasing patient choice in primary care: the management of minor ailments. *Health Econ*, 13, 73-86.

BOND, C. (2003) Evolution and Change in Community Pharmacy. *Report for the Royal Pharmaceutical Society of Great Britain*. Departments of General Practice and Primary Care and Management Studies, University of Aberdeen

- BOND, C. & HANNAFORD, P. (2003) Issues related to monitoring the safety of over-the-counter (OTC) medicines. *Drug Safety*, 26, 1065-1074.
- BOND, C. M. & BRADLEY, C. (1996). Over the counter drugs. The interface between the community pharmacist and patients. *BMJ*, 312, 758-60.
- BOWLING, A. (1997). *Research Methods in Health. Investigating health and health services*. 1<sup>st</sup> edition. Open University Press. Buckingham
- BRADLEY, C. P. (2009). The future role of pharmacists in primary care. *British Journal of General Practice*, 59, 891-892.
- BRADLEY, C. & BOND, C. (1995) Increasing the number of drugs available over the counter: arguments for and against. *The British Journal Of General Practice*, 45, 553-556.
- BRADLEY, C., TAYLOR, R. & BLENKINSOPP, A. (1997). Primary care--opportunities and threats. Developing prescribing in primary care. *BMJ (Clinical Research Ed.)*, 314, 744-747.
- BRAUN, V and CLARKE, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2): 77 - 101
- BRAZIER, J., JONES, N. & KIND, P. (1993) Testing the validity of the Euroqol and comparing it with the SF-36 health survey questionnaire. *Qual Life Res*, 2, 169-80.
- BREWER, J.D. (2000). *Ethnography*. Buckingham: Open University Press.
- BRITISH MEDICAL ASSOCIATION and NATIONAL PHARMACY ASSOCIATION (BMA and NPA) (2009). *Improving Communication Between community pharmacy and general practice*. NPA publications, St Albans.
- BRITTEN, N (1995). Qualitative Research: Qualitative interviews in medical research. *BMJ*; 311 : 251 (July)
- BRITTEN, N. & UKOUMUNNE, O. (1997). The influence of patients' hopes of receiving a prescription on doctors' perceptions and the decision to prescribe: a questionnaire survey. *BMJ*, 315, 1506-10.
- BRITTEN N, STEVENSON F, GAFARANGA, J, BARRY C, BRADLEY C. (2004). The expression of aversion to medicines in general practice consultations. *Soc Sci Med*; 59: 1495-503.
- BRYMAN, A (2001). *Social Research methods*. Oxford University Press, New York (1<sup>st</sup> edition)
- BRYMAN, A (2004). *Social Research methods*. Oxford University Press, New York (2<sup>nd</sup> edition)
- BUTLER, C. C., ROLLNICK, S., PILL, R., MAGGS-RAPPORT, F. & STOTT, N. (1998) Understanding the culture of prescribing: qualitative study of general practitioners' and patients' perceptions of antibiotics for sore throats. *BMJ*, 317, 637-642.
- CALAPAI, G. (2008) European legislation on herbal medicines - A look into the future. *Drug Safety*, 31, 428-431.

CANTRILL, J., JOHANNESSON, B., NICOLSON, M. & NOYCE, P. (1996). Management of minor ailments in primary schoolchildren in rural and urban areas. *Child Care Health Dev*, 22, 167-74.

CANTRILL, J., MORRIS, C. & WEISS, M. (2006) How patients perceive minor illness and factors influencing seeing a doctor. *Primary Health Care Research & Development*, 7, 157-164.

CARR-HILL, R. & RUDAT, K. (1995) Ethnic minority health. Unsound barrier. *Health Service Journal*, 105, 28-9.

CARR-HILL, R., RICE, N. & ROLAND, M. (1996). Socioeconomic determinants of rates of consultation in general practice based on fourth national morbidity survey of general practices. *BMJ*, 312, 1008-12.

CBI (2007). Just what the patient ordered: better GP services. (Report)  
[http://www.cbi.org.uk/ndbs/press.nsf/0363c1f07c6ca12a8025671c00381cc7/f60cebe0663c98d68025734600573f81/\\$FILE/CBI%20report%20'Just%20what%20the%20patient%20ordered'%20September%202007.pdf](http://www.cbi.org.uk/ndbs/press.nsf/0363c1f07c6ca12a8025671c00381cc7/f60cebe0663c98d68025734600573f81/$FILE/CBI%20report%20'Just%20what%20the%20patient%20ordered'%20September%202007.pdf) (accessed Dec 2008).

CHAPPLE, A. (1998) Iron deficiency anaemia in women of South Asian descent: a qualitative study. *Ethn Health*, 3, 199-212.

CHAPPLE, A. (2001). Vaginal thrush: perceptions and experiences of women of South Asian descent. *Health Educ. Res.*, 16, 9-19.

CHAPPLE, A., LING, M. & MAY, C. (1998) General practitioners' perceptions of the illness behaviour and health needs of South Asian women with menorrhagia. *Ethn Health*, 3, 81-93.

CHARMAZ, K (1983) "The grounded theory method: An explication and interpretation", in *Contemporary field Research: A Collection of Readings*, Robert M. Emerson, ed., Boston: Little, Brown and Company, 109-128.

CHISHOLM, A., REEVES, R., GRAHAM, C. & BULLEN, N. (2004) Patient survey report 2004 - primary care. Oxford. The Picker Institute, Europe and the Healthcare Commission.

CHRISTOPHER, D. & KENDRICK, D. (2004) Differences in the process of diabetic care between south Asian and white patients in inner-city practices in Nottingham, UK. *Health Soc Care Community*, 12, 186-93.

CLIFFORD, S., BARBER, N., ELLIOTT, R.A., HARTLEY, E. AND HORNE, R. (2006) *Patient-centred advice is effective in improving adherence to medicines*. Pharmacy World and Science, 28 (3). pp. 165-170.

COLLINS, G. S. & JOHNSON, M. R. D. (2008) Addressing ethnic diversity in health outcome measurement: a systematic and critical review of the literature. (Draft version of report)  
[http://www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/research/ethtom\\_final\\_draft.pdf](http://www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/research/ethtom_final_draft.pdf) (accessed April 2010)

COMMANDER, M. J., ODELL, S. M., SURTEES, P. G. & SASHIDHARAN, S. P. (2004) Care pathways for south Asian and white people with depressive and anxiety disorders in the community. *Social Psychiatry and Psychiatric Epidemiology*, 39, 259-264.

COMMITTEE OF INQUIRY (1986). Pharmacy. A report to the Nuffield Foundation. London: Nuffield Foundation.

COMMUNITIES IN ACTION (2007). Ramadan health guide: a guide to healthy fasting. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_078408.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_078408.pdf) (accessed Dec 2009)

COOPER, D. & CHINEMANA, F. (2004) NHS Direct derived data: an exciting new opportunity or an epidemiological headache? *J Public Health (Oxf)*, 26, 158-60.

COOPER, H., SMAJE, C. & ARBER, S. (1998) Use of health services by children and young people according to ethnicity and social class: secondary analysis of a national survey. *BMJ*, 317, 1047-1051.

COOPER, RJ, BISSELL, P; WINGFIELD, J (2009). 'Islands' and 'doctor's tool': the ethical significance of isolation and subordination in UK community pharmacy. *Health (London)*; 13: 297-316

CROMBIE I K & DAVIES, H. O. (1997) *Research in Health Care: Design, Conduct and Interpretation of Health Services Research*, Wiley.

CRUESS, R; CRUESS, S and JOHNSTON, S. (2000). Professionalism: an ideal to be sustained. *The Lancet*, 356 : 156-159 (July).

CRUESS, S; JOHNSTON, S. & CRUESS, R. (2004) Professionalism for medicine: opportunities and obligations. *Iowa Orthop J*, 24, 9-14.

CULLEY, L. (1996). A critique of multiculturalism in health care: the challenge for nurse education. *J Adv Nurs*, 23, 564-70.

CULLEY, L. (2000) 'Working with diversity: beyond the factfile' in Davies, C. Finlay, L. and Bullman, A. (eds) *Changing Practice in Health and Social Care* London: Sage/ Open University Press pp.131-42

CULLEY, L (2006). Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry* 13 (2): 144–153

CULLEY, L. & DYSON, S. (2001) *Ethnicity and Nursing Practice*, Palgrave.

CULLEY, L; RAPPORT, F; KATBAMNA, S; JOHNSON, MRD; HUDSON, N (2004). A Study of the Provision of Infertility Services to South Asian Communities. Final report. DeMontfort University.

CULLEY, L., HUDSON, N., JOHNSON, M.R.D., BHARADWAJ, A. & RAPPORT, F. (2005) Gamete donation and British South Asian communities. *Journal of Reproductive and Infant Psychology*, 23, 264-265.

CULLEY, L., HUDSON, N., JOHNSON, M. R. D., BHARADWAJ, A. & RAPPORT, F. L. (2006a) British South Asian women's perceptions of oocyte donation. *Human Reproduction*, 21, 1215- 1225.

CULLEY, L. A., HUDSON, N., RAPPORT, F. L., KATBAMNA, S. & JOHNSON, M. R. D. (2006b) British South Asian communities and infertility services. *Hum Fertil (Camb)*, 9, 37-45.

CULLEY, L., HUDSON, N. & RAPPORT, F. (2007a) Using Focus Groups with Minority Ethnic Communities: Researching Infertility in British South Asian Communities. *Qualitative Health Research*, 17, 102-112.



- CULLEY, L., HUDSON, N., JOHNSON, M. R. D., RAPPORT, F. & KATBAMNA, S. (2007b) 'I know about one treatment where they keep the egg somewhere': British South Asian community understandings of infertility and its treatment. *Diversity in Health and Social Care*, 4, 113-121.
- CULLEY, L & DYSON, S (2010). *Ethnicity and Healthcare Practice: A guide for the Primary Care Team*. Quay Books, Cambridge.
- D'ARCY, P. (1991) Lead poisoning with the use of Asian medicine. *International Pharmacy Journal*, 5, 248.
- DEIN, S. (1997) ABC of mental health. Mental health in a multiethnic society. *BMJ*, 315, 473-6.
- DEIN, S. (2006) Race, culture and ethnicity in minority research: a critical discussion. *Journal of Cultural Diversity*, 13, 68-75.
- DENNING, S. (2000). *The Springboard: How Storytelling Ignites Action in Knowledge-Era Organizations*. Boston, London, Butterworth Heinemann (October )
- DENZIN, N. & LINCOLN, Y. (2005) *The Sage Handbook of Qualitative Research* (3rd edition). Sage Publication.
- DEPARTMENT OF HEALTH (1987). Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. Promoting better health. London: HMSO
- DEPARTMENT OF HEALTH (1991). *The Patient's Charter*. London: HMSO.
- DEPARTMENT OF HEALTH (1992). *The Health of the Nation - a strategy for health in England*. London HMSO.
- DEPARTMENT OF HEALTH (1996). *Choice and opportunity Primary care delivering the future*. Department of Health. The Stationery Office. London
- DEPARTMENT OF HEALTH (1997). *The new NHS: modern, dependable*. London HMSO
- DEPARTMENT OF HEALTH (1998). *Our healthier nation a contract for health*. Department of Health. The Stationery Office. London
- DEPARTMENT OF HEALTH (1999) *Saving Lives: Our Healthier Nation*. London, Department of Health. The Stationery office. London
- DEPARTMENT OF HEALTH (2000a). *Assessing Children in Need and their Families*. Department of Health: The Stationery Office. London. Page 47
- DEPARTMENT OF HEALTH (2000b) *Pharmacy in the Future – Implementing the NHS Plan*. A programme for pharmacy in the National Health Service. Department of Health. The Stationery office. London
- DEPARTMENT OF HEALTH (2000c). *The NHS Plan: a plan for investment, a plan for reform*. Department of Health Stationery office. London.
- DEPARTMENT OF HEALTH (2000d). *The Vital Connection: An equalities framework for the NHS*. Department of Health Stationery office. London.



DEPARTMENT OF HEALTH (2001) Health survey for England: the health of minority ethnic groups 1999. Department of Health: [www.doh.gov.uk/public/england/htm](http://www.doh.gov.uk/public/england/htm) (accessed Dec 2007)

DEPARTMENT OF HEALTH (2002). Pharmacy workforce in the New NHS: Making the best use of staff to deliver the NHS Pharmacy Programme. Department of Health Stationery office. London.

DEPARTMENT OF HEALTH (2003a) A Vision for Pharmacy in the New NHS. Department of Health. The Stationery Office. London

DEPARTMENT OF HEALTH (2003b). Tackling health inequalities: A Programme for Action. Department of Health Stationery Office. London

DEPARTMENT OF HEALTH (2003c). Control of entry regulations and retail pharmacy services in the UK: Government response to the Health Select Committee (2002-03). Department of Health. The Stationery Office. London

DEPARTMENT OF HEALTH (2003d). Building on the best. Choice, responsiveness and equity in the NHS. Department of Health. The Stationery Office. London

DEPARTMENT OF HEALTH (2004a). The NHS Improvement Plan : Putting people at the heart of public services. Department of Health. The Stationery office. London

DEPARTMENT OF HEALTH (2004b). National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08. Department of Health. The Stationery office. London

DEPARTMENT OF HEALTH (2004c). Choosing Health: Making healthy choices easier. London, Department of Health. The Stationery office. London

DEPARTMENT OF HEALTH (2004d). Guidance on developing local communication support services and strategies. Department of health: the Equality and Human rights group. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4082350.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082350.pdf) (accessed Dec 2009)

DEPARTMENT OF HEALTH (2004e). Management of medicines: a resource to support implementation of the wider aspects of Medicines Management for the diabetes, renal and LTCs NSFs. Department of Health  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4088755.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4088755.pdf) (accessed November 2008)

DEPARTMENT OF HEALTH (2005a) Choosing Health through Pharmacy. A programme for Pharmaceutical Health 2005-2015. Department of Health. The Stationery office. London  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4107494](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4107494) (accessed Dec 2007)

DEPARTMENT OF HEALTH (2005b). A practical guide to ethnic monitoring in the NHS and social care. Health and Social Care Information Centre. Department of Health. The Stationery office. London  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4116843.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4116843.pdf) (accessed July 2007)

DEPARTMENT OF HEALTH (2005c). Health Survey for England: The Health of Minority Ethnic Groups.2004, NHS Health and Social Care Information Centre, Public Health Statistics. Department of Health. The Stationery office. London.

DEPARTMENT OF HEALTH (2005d). The new Community Pharmacy Contractual Framework (CPCF). Implementing the new community pharmacy contractual framework: information for primary care trusts. Department of Health. The Stationery office. London.

DEPARTMENT OF HEALTH (2005e). Health reform in England: update and next steps. Department of Health Stationery office. London.  
[http://www.connectingforhealth.nhs.uk/resources/policyandguidance/health\\_reform.pdf](http://www.connectingforhealth.nhs.uk/resources/policyandguidance/health_reform.pdf)  
(accessed Dec 2007)

DEPARTMENT OF HEALTH (2005f). Public Attitudes to Self Care - Baseline Survey, February 2005. Department of Health. The Stationery office. London  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4111264.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4111264.pdf) (accessed Dec 2008).

DEPARTMENT OF HEALTH (2005g). Research governance framework for health and social care: Second edition. Department of Health website  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4108962](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962) (accessed Dec 2008).

DEPARTMENT OF HEALTH (2005h). Race Equality Scheme 2005-2008. Department of Health website  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4112159.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4112159.pdf)

DEPARTMENT OF HEALTH (2006). Our health, our care, our say: a new direction for community services. Department of Health. The Stationery office. London

DEPARTMENT OF HEALTH (2007a) Positive steps: supporting race equality in mental healthcare. Department of Health. The Stationery office. London

DEPARTMENT OF HEALTH (2007b). Research evidence on the effectiveness of self care support (work in progress 2005-07). Department of Health. London  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_081251.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081251.pdf) (accessed Dec 2009).

DEPARTMENT OF HEALTH (2007c). Commissioning framework for health and well-being. Department of Health. The Stationery office. London  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_072604](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604) (accessed Dec 2008)

DEPARTMENT OF HEALTH (2007d). Our NHS Our future: NHS next stage review - interim report. First stage report Lord Darzi (author). Department of Health Stationery office.  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_079087.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079087.pdf) (accessed Jun 2009)

DEPARTMENT OF HEALTH (2007e). The GP Patient Survey 2006/2007 for the Department of Health. Ipsos MORI.

DEPARTMENT OF HEALTH (2008a) Partial Impact Assessment of proposals to expand the provision of minor ailment services. Department of Health. The Stationery office. London

DEPARTMENT OF HEALTH (2008b) Pharmacy in England: Building on strengths – delivering the future. Department of Health. The Stationery office. London  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_083815](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083815) (accessed July 2008)

DEPARTMENT OF HEALTH (2008c) High Quality Care for all: NHS next stage review. Lord Darzi (Ed.). London, Department of Health. The Stationary Office. London

DEPARTMENT OF HEALTH (2008d). Community Pharmacy Use (Quantitative and Qualitative Research. Market Research Report by The Central Office of Information (COI).  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_083870.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083870.pdf) (accessed Dec 2009).

DEPARTMENT OF HEALTH (2008e). Self care: a national view in 2007 compared to 2004-05. Department of Health. The Stationery Office. London.  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085351](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085351) (accessed Dec 2009).

DEPARTMENT OF HEALTH (2008f). Report of the National Improvement Team for primary care access and responsiveness. Department of Health. The Stationery Office. London.

DEPARTMENT OF HEALTH (2008g). Healthy weight, healthy lives: a cross-government strategy for England. . Department of Health. The Stationery Office. London  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_082378](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378) (accessed Sept 2009)

DEPARTMENT OF HEALTH (2008h). Health inequalities: progress and next steps. Department of Health. The Stationery Office. London  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085307](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085307) (accesses Sept 2009)

DEPARTMENT OF HEALTH (2009). A Year of Progress towards high quality care for all. . Department of Health. The Stationery Office. London

DEPARTMENT OF HEALTH (2010). Equity and excellence: Liberating the NHS. The Stationery Office. London

DEY, I. (1993) *Qualitative data analysis: a user friendly guide for social scientists*, London and New York, Routledge.

DICK, B. (1999) Sources of rigour in action research: addressing the issues of trustworthiness and credibility. A paper presented at the Association for Qualitative Research Conference "Issues of rigour in qualitative research" at the Duxton Hotel, Melbourne, Victoria, 6-10 July 1999. Available on line at  
[http://www.uq.net.au/action\\_research/arp/rigour3.html](http://www.uq.net.au/action_research/arp/rigour3.html) (accessed Dec 2007)

DINNIE, E., BOND, C. & WATSON, M. (2004) Community pharmacists' attitudes to medicines management: a qualitative study. *International Journal of Pharmacy Practice*, 12, 217-222.

DOGRA, N. (2005) Cultural diversity teaching in the medical undergraduate curriculum. *Diversity in Health and Social Care*, 2, 233-245.

- DOGRA, N., VOSTANIS, P., ABUATEYA, H. & JEWSON, N. (2005) Understanding of mental health and mental illness by Gujarati young people and their parents. *Diversity in Health and Social Care*, 2, 91-98.
- DOSHANI A, PITCHFORTH E, MAYNE C. J & TINCELLO DG (2007) Culturally sensitive continence care: a qualitative study among South Asian Indian women in Leicester. *Family Practice*, 24, 585-593.
- DUDDU, V., HUSAIN, N. & DICKENS, C. (2008) Medically unexplained presentations and quality of life: A study of a predominantly South Asian primary care population in England. *Journal of Psychosomatic Research*, 65, 311-317.
- DURAN-TAULERIA, E., RONA, R. J., CHINN, S. & BURNEY, P. (1996) Influence of ethnic group on asthma treatment in children in 1990-1: national cross sectional study. *BMJ*, 313, 148-152.
- DYCK, I. (2006) Travelling tales and migratory meanings: South Asian migrant women talk of place, health and healing. *Social & Cultural Geography*, 7, 1-18.
- DYER, R (1997). *White: Essays on Race and Culture* (London: Routledge)
- DYSON, S (2005). Ethnic question & antenatal screening for sickle cell / thalassaemia [EQUANS]. Policy Briefing Paper 2002-5. De Montfort University.
- EBRAHIM, S., PATEL, N., COATS, M., GREIG, C., GILLEY, J., BANGHAM, C. & STACEY, S. (1991) Prevalence and Severity of Morbidity Among Gujarati Asian Elders: a Controlled Comparison. *Fam. Pract.*, 8, 57-62.
- EAST MIDLANDS PUBLIC HEALTH OBSERVATORY (EMPHO) (2004a). Information Resources on Ethnicity and Health and Health Care  
[http://www.empho.org.uk/Download/Public/8371/1/consolidated\\_ethnicity\\_reportv2.pdf](http://www.empho.org.uk/Download/Public/8371/1/consolidated_ethnicity_reportv2.pdf)  
(accessed Dec 2007)
- EAST MIDLANDS PUBLIC HEALTH OBSERVATORY (EMPHO) (2004b). Public Eye Issue 4: South Leics PCT newsletter 2004  
[http://www.empho.org.uk/Download/Public/8373/1/publiceye\\_newsletter1.pdf](http://www.empho.org.uk/Download/Public/8373/1/publiceye_newsletter1.pdf) (accessed Dec 2007)
- EAST MIDLANDS PUBLIC HEALTH OBSERVATORY (EMPHO) (2005a). Demography of ethnic populations in the East Midlands. Report. Appendix 2.  
<http://www.empho.org.uk/pages/viewResource.aspx?id=8748> (accessed Dec 2008)
- EAST MIDLANDS PUBLIC HEALTH OBSERVATORY (EMPHO) (2005b). Health Inequalities Report for Leicester Unitary Authority.  
[http://www.empho.org.uk/Download/Public/8907/1/LeicesterUA\\_1.pdf](http://www.empho.org.uk/Download/Public/8907/1/LeicesterUA_1.pdf) (accessed Dec 2008).
- ECCLES, R. & KOHLI, B. (1996) Primary Health Care for Black and Minority Ethnic people: A GP perspective. NHS Ethnic Health Unit.
- EDMUNDS, J. & CALNAN, M. W. (2001) The reprofessionalisation of community pharmacy? An exploration of attitudes to extended roles for community pharmacists amongst pharmacists and General Practitioners in the United Kingdom. *Social Science & Medicine*, 53, 943-955.

ERENS, P., PRIMATESTA, P. & PRIOR, G. (2001) Health Survey for England: The health of minority ethnic groups 1999. London, Department of Health.

ERWIN, J., BRITTEN, N. & JONES, R. (1996) General practitioners' views on over the counter sales by community pharmacists. *BMJ (Clinical Research Ed.)*, 312, 617-618.

EXWORTHY, M., STUART, M., BLANC, D. & MARMOT, M. (2003) *Tackling Health Inequalities since the Acheson Inquiry*, Joseph Rowntree Foundation.

FAROOQI, A. & BHAVSAR, M. (2001) Project Dil: a co-ordinated primary care and community health promotion programme for reducing risk factors of coronary heart disease amongst the south Asian community of Leicester-experiences and evaluation of the project. *Ethn Health*, 6, 265-275.

FAROOQI, A., NAGRA, D., EDGAR, T. & KHUNTI, K. (2000) Attitudes to lifestyle risk factors for coronary heart disease amongst South Asians in Leicester: a focus group study. *Fam Pract*, 17, 293-7.

FASSIL, J. (1996) Primary Health care for Black and Minority Ethnic people: A consumer perspective. NHS Ethnic health Unit.

FENNER L, BISSELL P, and ANDERSON, C (2004). Social Capital and Pharmacy: an exploratory study. Presented at the Health Services Research and Pharmacy Practice Conference, Kings College, London

FIKREE, F. F. & PASHA, O. (2004) Role of gender in health disparity: the South Asian context. *BMJ*, 328, 823-826.

FLEMING, J and WARD, D (1999). 'Researcher as empowerment: the social action approach', in W.Shera and L.Wells (eds), *Empowerment Practice in Social Work*, Toronto: Canadian Scholars' Press

FLEMING, J and WARD, D (2004) Chapter 9 - Methodology and practical application of the Social Action Research model in Rapport, F (Ed). *New Qualitative Methodologies in Health and Social Care Research*. Routledge, London. Pages 162 – 178

FORD, S. & JONES, K. (1995) Integrating pharmacy fully into the primary care team. *BMJ*, 310, 1620-1.

FOX, C. (2004) Heart disease and South Asians : delivering the National Service Framework for coronary heart disease.

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4098919.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4098919.pdf) (accessed Dec 2008)

FREE, C. (1998) Breaking down language barriers. Some ethnic groups may have problems in getting as far as a consultation. *BMJ*, 317, 816-7.

FREE, C., GREEN, J., BHAVNANI, V. & NEWMAN, A. (2003) Bilingual young people's experiences of interpreting in primary care: a qualitative study. *Br J Gen Pract*, 53, 530-5.

FREEMAN, G. K., RAI, H., WALKER, J. J., HOWIE, J. G., HEANEY, D. J. & MAXWELL, M. (2002) Non-English speakers consulting with the GP in their own language: a cross-sectional survey. *Br J Gen Pract*, 52, 36-8.

- FREIDSON, E (1970) *Profession of Medicine*. Dodd, Mead and Company, New York
- GHALAMKARI H, & JENKINS D. (2002) Can pharmacists be social entrepreneurs? *Pharmaceutical Journal*; 268:358
- GERARD, K., SALISBURY, C., STREET, D., POPE, C., & BAXTER, H. (2008) Is fast access to general practice all that should matter? A discrete choice experiment of patients' preferences *Journal of Health Services Research & Policy*, 13, 3-10.
- GERRISH, K. (2000) Researching ethnic diversity in the British NHS: methodological and practical concerns. *J Adv Nurs*, 31, 918-25.
- GERRISH, K. (2001) The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. *Journal of Advanced Nursing*, 33, 566-574.
- GERRISH, K., CHAU, R., SOBOWALE, A. & BIRKS, E. (2004) Bridging the language barrier: the use of interpreters in primary care nursing. *Health Soc Care Community*, 12, 407-13.
- GILANI, A. (2007). A Community Pharmacy Supplementary Prescribing Clinic. <http://www.sahf.org.uk/uploads/docs/files/13.pdf> (accessed Jan 2010).
- GILANI, A. (2008). How pharmacists can help address health inequalities in South Asians. *The Pharmaceutical Journal*, 281, 141-142.
- GILL, P., KAI, J., BHOPAL, R. & WILDE, S. (2000) *Health care needs assessment: black and minority ethnic groups*. , Abingdon, Radcliffe Medical Press.
- GILL, P., SCRIVENER, G., LLOYD, D. & DOWELL, T. (1995). The effect of patient ethnicity on prescribing rates. *Health Trends*, 27, 111-4.
- GILL, P. S., DOWELL, A. & HARRIS, C. M. (1997) Effect of doctors' ethnicity and country of qualification on prescribing patterns in single handed general practices: linkage of information collected by questionnaire and from routine data. *BMJ*, 315, 1590-4.
- GILL, P.S, KAI, J., BHOPAL R.S, WILD, S., (2007). Health Care Needs Assessment of Black and Minority Ethnic Groups. In: STEVENS, A., RAFTERY, J., MANT, J., SIMPSON, S, eds. *The Epidemiologically Based Health Needs Assessment Reviews*. Radcliffe.
- GILLAM, S. (1990) Ethnicity and the use of health services. *Postgrad Med J*, 66, 989-93.
- GILLAM, S. J. (1991) Understanding the uptake of cervical cancer screening: the contribution of the health belief model. *Br J Gen Pract*, 41, 510-3.
- GILLAM, S. J., JARMAN, B., WHITE, P., and LAW, R. (1989) Ethnic differences in consultation rates in urban general practice. *BMJ*, 299, 953-7.
- GLASER, B. (1992) *Emergence versus Forcing: Basics of Grounded theory Analysis*, Mill Valley CA, Sociology PR.
- GLASER, B. & STRAUSS, A. (1967). *The basis of grounded theory: strategies for qualitative research*. Aldine , New York.



GOODBURN, E., MATTOSINHO, S., MONGI, P. & WATERSTON, T. (1991) Management of childhood diarrhoea by pharmacists and parents: is Britain lagging behind the Third World? *BMJ*, 302, 440-3.

GOODYER, L. (2004) *Travel Medicine for Health Professionals*, London, The Pharmaceutical Press.

GOODYER, L., SAVAGE, I. & DIKMEN, Z. (2006) Inhaler technique in Turkish people with poor English: a case of information discrimination? *Pharm World Sci*, 28, 107-14.

GOODYER, L. and BURNHAM, B. (2009). Differences in drug response between ethnic groups: the need for pharmaco-vigilance. *NLEH Ethnicity and Health Annual Evidence Update*.

GRACE C, BEGUM R, SUBHANI S, KOPELMAN P, GREENHALGH T. (2008) Prevention of Type 2 diabetes in British Bangladeshis: Qualitative study of community, religious and professional perspectives. *BMJ* 337: a1931.

GRAY, N., CANTRILL, J. & NOYCE, P. (2002). 'Health repertoires': an understanding of lay management of minor ailments. *Patient Education and Counseling*, 47, 237-244.

GREASLEY, P. & SMALL, N. (2005). Providing welfare advice in general practice: referrals, issues and outcomes. *Health & Social Care in the Community*, 13, 249-258.

GREENHALGH, T., HELMAN, C. and CHOWDHURY, A. (1998). Health beliefs and folk models of diabetes in British Bangladeshis: a qualitative study. *BMJ*, 316, 978 - 983.

GREENHALGH T. (2005) Barriers to concordance with antidiabetic drugs—cultural differences or human nature? *British Medical Journal* ; 330(7502): 1250. (May 28)

GREENHALGH, T., COLLARD, A. & BEGUM, N. (2005) Sharing stories: complex intervention for diabetes education in minority ethnic groups who do not speak English. *BMJ*, 330, 628 - 631.

GRIFFITHS, C., FOSTER, G., BARNES, N., ELDRIDGE, S., TATE, H., BEGUM, S., WIGGINS, M., DAWSON, C., LIVINGSTONE, A. E., CHAMBERS, M., COATS, T., HARRIS, R. & FEDER, G. S. (2004) Specialist nurse intervention to reduce unscheduled asthma care in a deprived multiethnic area: the east London randomised controlled trial for high risk asthma (ELECTRA). *BMJ*, 328, 144-147.

HABERMAS J. 1981. *The Theory of Communicative Action*. Vol 2. Cambridge: Polity Press, (cited in Kelleher and Islam (1994).

HAJAT, H. (1999) Ethnic responsiveness in Pharmacy's new age. *The Pharmaceutical Journal*, 263, 52.

HAMILTON, M. & ESSAT, Z. (2008). Be nice-smile as you do with everyone: Learning multi-cultural Nursing in Leicester. *Mary Seacole Research Paper 2*. Leicester, Mary Seacole Research Centre, DeMontfort University.

HAMMOND, T., CLATWORTHY, J. & HORNE, R. (2004) Patients' use of GPs and community pharmacists in minor illness: A cross-sectional questionnaire-based study. *Family Practice*, 21, 146-149.

HANCOCK, B. (1998). An introduction to Qualitative Research, Trent Focus for research and Development in Primary health care.

HARDING, G. & TAYLOR, K. M. (1990) Professional relationships between general practitioners and pharmacists in health centres. *The British Journal of General Practice*, 40, 464-466.

HARGIE, O., MORROW, N. & WOODMAN, C. (1992) Consumer perceptions of and attitudes to community pharmacy services. *The Pharmaceutical Journal*, 249, 688-691.

HARGIE, O. D., MORROW, N. C. & WOODMAN, C. (2000) Pharmacists' evaluation of key communication skills in practice. *Patient Educ Couns*, 39, 61-70.

HASSELL, K. (2000a) Diverted traffic: GP workload can be cut.... *Health Services Journal*, 22-3

HASSELL, K (2004). Briefing Paper on Pharmacist's Workforce Characteristics in Leicestershire, Northamptonshire and Rutland SHA. Based On Data From The Pharmacy Workforce Census 2003 . Briefing paper no. 3. The Centre for Pharmacy Workforce Studies, University of Manchester

HASSELL, K. (2006). Destination, future intentions and views on practice of British-based pharmacists 5 and 10 years after qualifying. *Pharm World Sci*, 28, 116-22.

HASSELL, K., HARRIS, J., ROGERS, A., NOYCE, P. & WILKINSON, J. (1996). The role and contribution of pharmacy in primary care. Manchester, National Primary Care Research and Development Centre.

HASSELL, K., NOYCE, P. R., ROGERS, A., HARRIS, J. & WILKINSON, J. (1997). A pathway to the GP: the pharmaceutical 'consultation' as a first port of call in primary health care. *Fam. Pract.*, 14, 498-502.

HASSELL, K., NOYCE, P. & ROGERS, A. (1999). A review of factors that influence the use of community pharmacies as a health care resource. *International Journal of Pharmacy Practice*, 7, 51-59.

HASSELL, K., NOYCE, P., ROGERS, A., HARRIS, J. & WILKINSON, J. (1998) Advice provided in British community pharmacies: what people want and what they get. *J Health Serv Res Policy*, 3, 219-25.

HASSELL, K., ROGERS, A. & NOYCE, P. (2000b) Community pharmacy as a primary health and self-care resource: a framework for understanding pharmacy utilization. *Health & Social Care in the Community*, 8, 40-49.

HASSELL, K., WHITTINGTON, Z., CANTRILL, J., BATES, F., ROGERS, A. & NOYCE, P. (2001) Managing demand: transfer of management of self limiting conditions from general practice to community pharmacies. *BMJ*, 323, 146-147.

HAWTHORNE, K. (1990) Asian diabetics attending a British hospital clinic: a pilot study to evaluate their care. *Br J Gen Pract*, 40, 243-7.

HAWTHORNE, K. (1997). Views of Asians and non-Asians on over-the-counter medication. *Br J Gen Pract*, 47, 125.



HAWTHORNE, K. (2001) Effect of culturally appropriate health education on glycaemic control and knowledge of diabetes in British Pakistani women with type 2 diabetes mellitus. *Health Educ. Res.*, 16, 373-381.

HAWTHORNE, K., MELLO, M. & TOMLINSON, S. (1993) Cultural and religious influences in diabetes care in Great Britain. *Diabet Med*, 10, 8-12.

HAWTHORNE, K. & TOMLINSON, S. (1997) One-to-one teaching with pictures--flashcard health education for British Asians with diabetes. *Br J Gen Pract*, 47, 301-4.

HEALTHCARE COMMISSION (2009). Annual report and accounts 2008/09 Our work to improve healthcare for patients and the public HMSO London

HEALTH PROTECTION AGENCY (HPA) (2007). Maintaining momentum. Annual report of the National Chlamydia Screening Programme in England 2006/07. [http://www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1204013012687](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1204013012687) (accessed Jun 2010)

HEALTH PROTECTION AGENCY (HPA). (2008a). Foreign travel-associated illness – a focus on those visiting friends and relatives 2008 report. [http://www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1231419800356](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1231419800356) (accessed September 2010).

HEALTH PROTECTION AGENCY (HPA). (2008b). Antimicrobial Resistance and Prescribing in England, Wales and Northern Ireland. London: Health Protection Agency, July [http://www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1216798080469](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1216798080469) (accessed Jan 2010).

HEIDEGGER M. (1996), Being and Time, translated by Joan Stambaugh. Albany: State University of New York Press.

HELMAN, C. (1994). Culture, health and Illness. Butterworth-Heinemann.

HEPLER CD, STRAND LM. (1990). Opportunities and responsibilities in pharmaceutical care. *Am J Hosp Pharm*.;47:533-543.

HIBBERT, D., BISSELL, P. and WARD, P. (2002). Consumerism and professional work in the community pharmacy. *Sociology of Health & Illness*, 24, 46-65.

HIGGINBOTTOM, G (2008). "I didn't tell them. Well, they never ask". Lay understandings of hypertension and their impact on chronic disease management: implications for nursing practice in primary care. *Journal of Research in Nursing*, 13(2): 89-99

HODGSON, C. & WONG, I. (2004). What do mothers of young children think of community pharmacists? A descriptive survey. *J Fam Health Care*, 14, 73-4, 76-9.

HORNE R, WEINMAN J, BARBER N, ELLIOT R, MORGAN M. (2005). Concordance, adherence and compliance in medicine taking. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D ( publishers NCCSDO)

HOWARD, M., HIRST, J. and RUTHERFORD, A. (2007). Umda Dawa - a new approach to using medicines effectively in Bristol. *The Pharmaceutical Journal*, 278, 251-252.

HOWIE, J. G., HEANEY, D. J., MAXWELL, M., WALKER, J. J., FREEMAN, G. K. and RAI, H. (1999). Quality at general practice consultations: cross sectional survey. *BMJ*, 319, 738-43.

- HUCKERBY, C., HESSLEWOOD, J. & JAGAL, P. (2006) Taking health care into black and minority communities: a pharmacist-led initiative. *The Pharmaceutical Journal*, 276, 680-682.
- HUDSON, N., CULLEY, L., JOHNSON, M.R.D., KATBAMNA, S. & RAPPORT, F. (2005) Exploring social constructions of infertility amongst British South Asian communities. *Journal of Reproductive and Infant Psychology*, 23, 273-274.
- HUGHES, C. M. & MCCANN, S. (2003) Perceived interprofessional barriers between community pharmacists and general practitioners: a qualitative assessment. *The British Journal Of General Practice*, 53, 600-606.
- HUNT, S. & BHOPAL, R. (2003) Self reports in research with non-English speakers: The challenge of language and culture is yet to be met. *BMJ*, 327, 352-3.
- HUSSAIN, F. & COCHRANE, R. (2004) Depression in South Asian women living in the UK: a review of the literature with implications for service provision. *Transcult Psychiatry*, 41, 253-70.
- HUSSAIN-GAMBLES, M. (2004) South Asian patients' views and experiences of clinical trial participation. *Fam. Pract.*, 21, 636-642.
- HUSSAIN-GAMBLES, M., ATKIN, K. & LEESE, B. (2006) South Asian participation in clinical trials: The views of lay people and health professionals. *Health Policy*, 77, 149-165.
- IPSOS MORI (2008). NHS Leicester City Residents Survey. Research among Leicester City Residents. Conducted on behalf of Leicester City NHS.  
<http://consultations.leicester.gov.uk/feedback.aspx?Con1=209> (accessed Dec 2009)
- IQBAL, G; GUMBER, A; JOHNSON, M.R.D; SZCZEPURA, A; WILSON, S; DUNN, JA (2009). Improving ethnicity data collection for health statistics in the UK *Diversity in Health & Care* 6, 4: 267-285 (Dec)
- ISMAIL, H., WRIGHT, J., RHODES, P. & SMALL, N. (2005). Religious beliefs about causes and treatment of epilepsy. *Br J Gen Pract*, 55, 26-31.
- IVERSEN, L., MOLLISON, J. & MACLEOD, T. N. N. (2001) Attitudes of the general public to the expanding role of community pharmacists: a pilot study. *Fam. Pract.*, 18, 534-536.
- JACKSON, M. & PETERS, J. (2003) Introducing touchscreens to black and ethnic minority groups: a report of processes and issues in the Three Cities project. *Health Information & Libraries Journal*, 20, 143.
- JACKSON, M. & SKINNER, J. (2006) Improving consultations in general practice for non English-speaking patients. *Br J Gen Pract*, 56, 627-8.
- JACOB, K. S., BHUGRA, D., LLOYD, K. R. & MANN, A. H. (1998) Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *J R Soc Med*, 91, 66-71.
- JAIN, N., FAROOQI, A. & FEEHALLY, J. (2008) Raising awareness of chronic kidney disease among South Asians and primary care: the ABLE project. *J Ren Care*, 34, 173-8.
- JEPSON, M., JESSON, J., KENDALL, H., POCOCK, R., (1991). Consumer expectations of community pharmacy services. A report for the Department of Health. Birmingham: Aston University/M.E.L Research

JESSA, F. N. (1994) Are TB patients misunderstood? An evaluation of a translated antituberculosis patient information leaflet within the Pakistani community and a study of TB compliance during Ramadan. *Hospital Pharmacy Practice*, 4, 159-160.

JESSON, J. (1998) In the Minority. *Chemist and druggist*, 6-8.

JESSON, J. (2001) Cross-sectional studies in prescribing research. *J Clin Pharm Ther*, 26, 397-403.

JESSON, J., POCOCK, R; KENDALL, H and JEPSON, M. (1991) Working Paper 5: Ethnic Minority communities and the Pharmacy: consumer views of its role and relevance. *Consumer expectations of community pharmacy services*. Birmingham, Aston University / MEL research.

JESSON, J., JEPSON, M., POCOCK, R., SADLER, S. & DUNBAR, P. (1994a) Working Paper 6: Ethnic minorities and the Community Pharmacist. Birmingham, Aston University/M.E.L Research.

JESSON, J., JEPSON, M., POCOCK, R., SADLER, S. & DUNBAR, P. (1994b) Final report: Ethnic minority Consumers of Community Pharmaceutical Services. Birmingham, Pharmacy Practice Research Group, Aston University/M.E.L Research, Aston Science Park.

JESSON, J., POCOCK, R., JEPSON, M. & KENDALL, H. (1994c) Consumer readership and views on pharmacy health education literature: market research survey. *Journal of Social & Administrative Pharmacy*, 11, 29-36.

JESSON, J., SADLER, S., POCOCK, R. & JEPSON, M. (1995) Ethnic minority consumers of community pharmaceutical services. *International Journal of Pharmacy Practice*, 3, 129-132.

JESSON, J. K. & WILSON, K. A. (2003) One-stop health centres: what co-location means for pharmacy. *Health Place*, 9, 253-61.

JESSON, J. (2007) Creating a demand for better health by using social marketing techniques. *The Pharmaceutical Journal*, 278, 776.

JOHNSON, M.R.D (1996). Ethnic Minorities, Health & Communication. A Research Review for the NHS Executive and West Midlands Regional Health Authority. Research Paper in Ethnic Relations No.24. Centre for Research in Ethnic Relations, University of Warwick, Coventry (March)

JOHNSON, M.R.D (1998). Involvement of black and ethnic minority consumers in health research. A research review. Working paper no 3. Mary Seacole Research Centre, DeMontfort University and University of Warwick; 1-19

JOHNSON, M.R.D (1999) Communication in healthcare: A review of some key issues. *NTRResearch*, 4, 18-30.

JOHNSON, M.R.D (2001). Transcultural communication and health care practice: Towards an epidemiology of diversity: Ethnic minority demography, disease patterns and pathways to care. Royal College of Nursing.  
[http://www.rcn.org.uk/development/learning/transcultural\\_health/epidemiologyofdiversity](http://www.rcn.org.uk/development/learning/transcultural_health/epidemiologyofdiversity)  
(accessed Feb 2006)

JOHNSON, M.R.D. (2003). Research governance and diversity: quality standards for a multi-ethnic NHS. *Nursing Times Research*, 8, 27-35.

- JOHNSON, M.R.D. (2004a) Cross-cultural communication in health. *Clin Cornerstone*, 6, 50-2.
- JOHNSON, M.R.D. (2004b) Faith, prayer, and religious observances. *Clin Cornerstone*, 6, 17-24.
- JOHNSON, M. R. D. (2006) Engaging Communities and Users: Health and Social Care Research with Ethnic Minority Communities. IN NAZROO, J. Y. (Ed.) *Health and Social Research in Multiethnic Societies*. London, Routledge.
- JOHNSON, M.R.D. (2008) Making Difference Count: Ethnic Monitoring in Health (and Social Care) in "Equity and Accountability in the NHS". *Radical Statistics*, 38-45.
- JOHNSON M.R.D, CROSS M, CARDEW S. (1983) Inner-city residents, ethnic minorities and primary health care. *Postgrad Med J* 1983;**59**: 664-667
- JOHNSON, M.R.D & GILL, P. (1995) Ethnic monitoring and equity: Collecting data is just the beginning (editorial). *BMJ*, 310, 890.
- JOHNSON, M.R.D. & VERMA, C. (1998) It's our health too: Asian men's health perspectives: summary report. The SAHARA project. *Research paper in ethnic relations no 26*. Warwick, Centre for research in ethnic relations, University of Warwick.
- JOHNSON, M.R.D., CLARK MD, OWENS D & A., S. (1999) The Unavoidable Costs of Ethnicity: A review of evidence on health costs. Coventry, Centre for Health Services Studies, University of Warwick, Coventry, UK.
- JOHNSON, M.R.D., OWEN D, BLACKBURN C, REHMAN H & J., N. (2000a) Black and Minority Ethnic Groups in England: The second health & lifestyles survey London. Health Education Authority.
- JOHNSON, M.R.D. & SCASE, M. (2000b) Ethnic minorities and visual impairment: A research review. *Seacole Research Paper 1*. Leicester, Mary Seacole Research Centre, DeMontfort University.
- JOHNSON, M.R.D. & JONES, K. (2003a) Everyone has own spirituality. *BMJ*, 327, 1049.
- JOHNSON, M.R.D. & SZCZEPURA, A. (2003b) Representation of South Asian people in randomised trials: population's ethnic profile should be recorded in all medical data. *BMJ*, 327, 394.
- JOHNSON, M.R.D., SAMANTA, A., HUDSON, N., CULLEY, L., GUO, F. & RAUF, A. (2006) Evaluation of Information resources on Osteomalacia in Asian Languages. *Mary Seacole research paper 6*. Leicester, Mary Seacole research centre, DeMontfort University.
- JONES, D. & GILL, P. (1998) Breaking down language barriers. The NHS needs to provide accessible interpreting services for all. *BMJ*, 316, 1476.
- KARLINER, L., JACOBS, E., CHEN, A. & MUTHA, S. (2007) Do Professional Interpreters Improve Clinical Care? *Health Serv Res*, 42, 727-754.
- KARLSEN, S. & NAZROO, J. Y. (2002) Relation between racial discrimination, social class, and health among ethnic minority groups. *American Journal of Public Health*, 92, 624-631.

- KAUR, M and DOBRZANSKI, S. (1988). Pharmacy counselling for patients of Indian/Pakistani origin. *British Journal of Pharmaceutical Practice*; 10 (8):345,348,350
- KAYNE, S. (2002) *Complementary Therapies for Pharmacists* London, Pharmaceutical Press.
- KELLEHER, D (1996). A defence of the use of the terms 'ethnicity and culture.' In: Kelleher D, Hillier S (editors). *Researching cultural differences in health*, London: Routledge.
- KELLEHER, D and HILLIER S (1996). *Researching cultural differences in health*. London: Routledge
- KELLEHER, D AND ISLAM, S (1994). The problem of integration: Asian people and diabetes. *Journal of the Royal Society of Medicine*; 87: 414-7
- KENNEDY, I (2001). Learning from Bristol. The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. [http://www.bristol-inquiry.org.uk/final\\_report/the\\_report.pdf](http://www.bristol-inquiry.org.uk/final_report/the_report.pdf) (accessed Dec 2009)
- KHANCHANDANI, R. & GILLAM, S. (1999). The ethnic minority linkworker: a key member of the primary health care team? *Br J Gen Pract*, 49, 993-4.
- KHUNTI K, KUMAR SUDHESH & BRODIE J (2009) Diabetes UK and South Asian Health Foundation recommendations on diabetes research priorities for British South Asians. South Asian Health Foundation.
- KHUNTI, K. & SAMANI, N. J. (2004) Coronary heart disease in people of south-Asian origin. *Lancet*, 364, 2077-2078.
- KITZINGER, J AND BARBOUR, R (1999). *Developing focus group research: politics, theory and practice*. Sage publications, London
- KNOWLES, E., MUNRO, J., O'CATHAIN, A. & NICHOLL, J. (2006) Equity of access to health care. Evidence from NHS Direct in the UK. *J Telemed Telecare*, 12, 262-5.
- KRSKA, J. & KENNEDY, E. J. (1996) Responding to symptoms: comparing general practitioners' and pharmacists' advice. *Pharmaceutical Journal*, 257, 322-324.
- KUMAR, D. M., SYMONDS, R. P., SUNDAR, S., IBRAHIM, K., SAVELYICH, B. S. P. & MILLER, E. (2004) Information needs of Asian and White British cancer patients and their families in Leicestershire: A cross-sectional survey. *British Journal of Cancer*, 90, 1474-1478.
- KUMAR, S., LITTLE, P. & BRITTEN, N. (2003). Why do general practitioners prescribe antibiotics for sore throat? Grounded theory interview study. *BMJ*, 326, 138-146.
- KUMARI, N (2004). South Asian women in Britain: their mental health needs and views of services. *Journal of Public Mental Health* , 3, 1: 30-38 (March)
- LACEY, A. & LUFF, D. (2001) *Qualitative data analysis*, Trent focus for research and development in Primary Health Care.
- LAKHANI, N. & ANDERSON, E. (2008) Interprofessional education: preparing future pharmacists for 2020. *The Pharmaceutical Journal*, 280, 571-2.



LAKHANI, N., JOHNSON, M.R.D., CANNABY, A. & FAROOQI, A. (2003) Role of the community pharmacist in health care needs for members of the South Asian minority ethnic population: general practitioner perspective. *International Journal of Pharmacy Practice*, 11, R95.

LAMBERT H and SEVAK, L (1996). Is "cultural difference" a useful concept? Perceptions of health and the sources of ill health among Londoners of South Asian origin, in *Researching Cultural Differences in Health*. Edited by Kelleher D, Hiller S. London, Routledge

LAWTON J, AHMAD N, HALLOWELL N, HANNA L, DOUGLAS M. (2005). Perceptions and experiences of taking oral hypoglycaemic agents among people of Pakistani and Indian origin: qualitative study. *British Medical Journal* ;330: 1247-9.).

LEICESTERSHIRE COUNTY COUNCIL (2005). Ethnicity in Leicestershire. Key Results from the 2001 census. Research and Information Team, Chief Executive's Department, County Hall, Leicestershire County Council  
([http://www.leics.gov.uk/ethnicity\\_in\\_leicestershire\\_web.pdf](http://www.leics.gov.uk/ethnicity_in_leicestershire_web.pdf) accessed Dec 2006)

LEININGER M. (1995) *Transcultural Nursing: Concepts, Theories, Research and Practices*. 2<sup>nd</sup> Ed. McGraw-Hill, New York

LEININGER, M and McFARLAND, M (2006). *Culture Care Diversity & Universality: A Worldwide Nursing Theory*, Second Edition. Jones and Bartlett (Pub)

LINDESAY, J., JAGGER, C., HIBBETT, M. J., PEET, S. & MOLEDINA, F. (1997) Knowledge, uptake and availability of health and social services among Asian Gujarati and white elderly persons. *Ethn Health*, 2, 59-69.

LLOYD, C., JOHNSON, M.R.D., MUGHAL, S., STURT, J., COLLINS, G., ROY, T., BIBI, R. & BARNETT, A. (2008) Securing recruitment and obtaining informed consent in minority ethnic groups in the UK. *BMC Health Services Research*, 8, 68.

LLOYD, C., MUGHAL, S., STURT, J., O'HARE, P. & BARNETT, A. (2006). Using self-complete questionnaires in a South Asian population with diabetes: problems and solutions. *Diversity in Health & Social Care*, 3, 245 - 51.

LLOYD, C., STURT, J., JOHNSON, M.R.D., MUGHAL, S., COLLINS, G. & BARNETT, A. (2008) Development of alternative modes of data collection in South Asians with Type 2 diabetes. *Diabetic Med*, 25, 455 - 62.

LLOYD-WILLIAMS, F. (2003). The effect of an intervention programme to improve health education leaflet uptake and distribution in community pharmacies. *Patient Educ Couns*, 49, 27-33.

LOEWENTHAL, K. M., CINNIRELLA, M., EVDOKA, G. & MURPHY, P. (2001) Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *Br J Med Psychol*, 74, 293-303.

MACFARLANE, G. J., LUNT, M., PALMER, B., AFZAL, C., SILMAN, A. J. & ESMAIL, A. (2007) Determining aspects of ethnicity amongst persons of South Asian origin: The use of a surname-classification programme (Nam Pehchan). *Public Health*, 121, 231-236.

MAKOUL G, ARNSTON P, SCOFIELD T. Health promotion in primary care: Physician-patient communication and decision about prescription medications. *Social Science & Medicine*.1995; 41: 1241-54.

MAGUIRE, P. & PITCEATHLY, C. (2002) Key communication skills and how to acquire them. *BMJ*, 325, 697-700.

MANIAS E and WILLIAMS A (2010) Medication adherence in people of culturally and linguistically diverse backgrounds: a meta-analysis. *Annals of Pharmacotherapy*; 44(6):964-82

MARINKER M, BLENKINSOPP A, BOND C. (1997). From compliance to concordance: achieving shared goals in medicine taking. London: Royal Pharmaceutical Society of Great Britain

MARK, A. L. & SHEPHERD, I. D. (2004) NHS direct: managing demand for primary care? *Int J Health Plann Manage*, 19, 79-91.

MARMOT, M.G., ADELSTEIN, A.M., BULUSU, L., AND OPCS (1984) *Immigrant mortality in England and Wales 1970–78: causes of death by country of birth*. London: HMSO.

MARMOT REVIEW (2010). Fair Society Healthy Lives. Strategic Review of Health Inequalities in England post 2010 (in press at time of thesis completion).

MAY, S. (1999) Critical Multiculturalism and Cultural Difference: avoiding essentialism, in S. May (Ed.) *Critical Multiculturalism: rethinking multicultural and antiracist education*. London: Falmer Press.

MAYS, N. & POPE, C. (1995). Qualitative Interviews in Medical Research. *BMJ* 311: 251 – 253.

MAYS, N. & POPE, C. (2000) Qualitative research in Health care: assessing quality in qualitative research. *BMJ*, 320(7226): 50–52 (Jan)

MCAVOY, B. R. & DONALDSON, L. J. (1990) *Health Care for Asians* Oxford General Practice.

MCAVOY, B. R. & RAZA, R. (1991) Can health education increase uptake of cervical smear testing among Asian women? *BMJ*, 302, 833-6.

MCCORMICK, A., FLEMING, D. & CHARTLON, J. (1995) Morbidity statistics from General Practice. *Office of Population Censuses and Surveys*, London, HMSO.

MCDONALD, R.; CHERAGHI-SOHI, S.; TICKLE, C.; ROLAND, M. Et al (2010a). The impact of incentives on the behaviour and performance of primary care professionals. Report for the National Institute for Health Research Service Delivery and Organisation programme (August). Queen's Printer and Controller of HMSO.

MCDONALD, R.; CHERAGHI-SOHI, S.; SANDERS, C.; ASHCROFT, D. (2010b)., Professional status in a changing world: The case of Medicines Use Reviews in English community pharmacy, *Social Science and Medicine*, Vol.71 (3), pp. 451-458.

MCELNAY, J. C., NICHOLL, A. J. & GRAINGER-ROUSSEAU, T. J. (1993) Role of the community pharmacist-survey of public opinion in Northern Ireland. *International Journal of Pharmacy Practice*, 2, 95-100.

- MCEVOY, P AND RICHARDS, D. (2003). Critical realism: a way forward for evaluation research in nursing? *Journal of Advanced Nursing*, 43(4): 411–420, August
- MCLEAN, C. A. & CAMPBELL, C. M. (2003) Locating research informants in a multi-ethnic community: ethnic identities, social networks and recruitment methods. *Ethn Health*, 8, 41 - 61.
- MCNAIR, R. (2005) The case for educating health care students in professionalism as the core content of interprofessional education. *Medical Education*, 39, 456-464.
- MACPHERSON, W. (1999). The Stephen Lawrence Inquiry: Report of an Inquiry, Home Office, February.
- MICHIE, C., CHAMBERS, J., ABRAMSKY, L. & KOONER, J. (1998). Folate deficiency, neural tube defects, and cardiac disease in UK Indians and Pakistanis. *Lancet*, 351, 1105.
- MILES, M and HUBERMAN, A. (1994). Qualitative Data Analysis. An expanded sourcebook. (2<sup>nd</sup> edition). Sage Publications, California
- MILLER L G (1998) Herbal medicinals: Selected clinical considerations focusing on known or potential drug-herb interactions. *Archives of Internal Medicine* 158: 2200–11
- MIR, G (2005). Social Policy and Health Inequalities: The relevance of faith to chronic illness management in the Pakistani community. PhD University of Leeds Medical School
- MODOOD, T., BERTHOUD, R., LAKEY, J, NAZROO J, SMITH, P., VIRDEE, S & BEISHON, S. (1997) Ethnic Minorities in Britain: Diversity and Disadvantage. London, Policy Studies Institute.
- MOODY, G. , EADEN, J. , BHAKTA, P., SHER, K. & MAYBERRY, J. (1998). The role of complementary medicine in European and Asian patients with inflammatory bowel disease. *Public Health*, 112, 269-71.
- MORENO-JOHN, G., GACHIE, A., FLEMING, C., NAPOLES-SPRINGER, A., MUTRAN, E., MANSON, S. & PEREZ-STABLE, E. J. (2004) Ethnic minority older adults participating in clinical research: developing trust. *J Aging Health*, 16, 93S-123S.
- MORGALL-TRAULSEN, J. & BISSELL, P. (2004). Theories of professions and the pharmacist. *International Journal of Pharmacy Practice*, 12, 107-114.
- MORJARIA-KEVAL, A. & JOHNSON, M.R.D. (2005). Our Vision too: Improving the Access of Ethnic Minority Visually Impaired People to Appropriate Services. *Mary Seacole Research Paper 4*. Leicester, Mary Seacole Research Centre, DeMontfort University.
- MORRIS, C., CANTRILL, J. & WEISS, M. C. (1997) One simple question should be enough: consumers' perceptions of pharmacy protocols. *International Journal of Pharmacy Practice*, 5, 64-71.
- MORRIS, C., CANTRILL, J. & WEISS, M. (2001a) GP survey response rate: a miscellany of influencing factors. *Fam Pract*, 18, 454-6.
- MORRIS, C., CANTRILL, J. & WEISS, M. (2001b) GPs' attitudes to minor ailments. *Fam Pract*, 18, 581-5.



- MORROW, N. & HARGIE, O. (1992) Patient counselling: an investigation of core situations and difficulties in pharmacy practice. *International Journal of Pharmacy Practice*, 1, 202-5.
- MORROW, N., HARGIE, O. & WOODMAN, C. (1993) Consumer perceptions of attitudes to the advice giving role of community pharmacists. *The Pharmaceutical Journal*, 251, 25-27.
- MOUDGIL, H., MARSHALL, T. & HONEYBOURNE, D. (2000) Asthma education and quality of life in the community: a randomised controlled study to evaluate the impact on white European and Indian subcontinent ethnic groups from socioeconomically deprived areas in Birmingham, UK. *Thorax*, 55, 177-183.
- MURPHY, A. & TALLIS, R. (2003) How to achieve concordance through ethnic sensitivity and lateral thinking: A case study. *Pharmaceutical Journal*, 271, 511-512.
- MURPHY, E., DINGWALL, R., GREATBATCH, D., PARKER, S. & WATSON, P. (1998) Qualitative research methods in health technology assessment: a review of the literature. *Health Technology Assessment*, 2; 1-275
- MYNORS, G., GHALAMKARI, H., BEAUMONT, S., POWELL, S. & MCGEE, P. (2004) Informed Choice in Medicine taking: Drugs of Porcine Origin and Clinical Alternatives: An Introductory Guide, Ask about medicines.
- NATIONAL INSTITUTE OF (Health and) CLINICAL EXCELLENCE (NICE). (2008) Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. London, NICE publications.  
<http://www.nice.org.uk/nicemedia/pdf/PH010guidance.pdf> (accessed March 2009).
- NATIONAL INSTITUTE OF (Health and) CLINICAL EXCELLENCE (NICE). (2009). Medicines adherence Involving patients in decisions about prescribed medicines and supporting adherence. London, NICE publications.  
<http://www.nice.org.uk/nicemedia/live/11766/43042/43042.pdf> (accessed December 2009).
- NATIONAL PRESCRIBING CENTRE (2004) Community Pharmacy Minor Ailment Schemes. *MeReC Briefing*, 1-8.
- NAZROO, J.Y. (1998) Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health. *Sociology of Health and Illness*, 20(5), 710–30.
- NAZROO, J.Y. (2001) *Ethnicity, class and health*. London: Policy Studies Institute.
- NAZROO, J.Y (2003) The Structuring of Ethnic Inequalities in Health: Economic Position, Racial Discrimination, and Racism. *American Journal of Public Health*, 92, 277–284.
- NAZROO, J. Y (2006) *Health and Social research in Multiethnic Societies*, Oxford and New York, Routledge.
- NHS HEALTH SCOTLAND (2008). Now we're talking: Interpreting guidelines for NHS staff in Scotland.  
<http://www.healthscotland.com/uploads/documents/7697-Nowwe'retalkinginterpretingguidelines.pdf> (accessed June 2010)
- NHS PROFESSIONALS (2005). Race Equality Scheme  
<http://www.nhsprofessionals.nhs.uk/download/key-documents/NHSRaceEqualityScheme2005.pdf> (accessed Jan 2009)

NEAL, R.,ALI, N., ATKIN, K., ALLGAR, V., ALI, S. & COLEMAN, T. (2006) Communication between South Asian patients and GPs: comparative study using the Roter Interactional Analysis System. *Br J Gen Pract*, 56; 869-875.

O'CATHAIN, A., GOODE, J., LUFF, D., STRANGLEMAN, T., HANLON, G. & GREATBATCH, D. (2005) Does NHS Direct empower patients? *Social Science & Medicine*, 61, 1761-71.

O'CONNELL, K. & SKEVINGTON, S. (2005). The relevance of spirituality, religion and personal beliefs to health-related quality of life: themes from focus groups in Britain. *Br J Health Psychol*, 10, 379-98.

O'DONNELL, C. A., HIGGINS, M., CHAUHAN, R. & MULLEN, K. (2007) "They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. *BMC Health Serv Res*, 7, 75.

O' HAGAN K. (2001) *Cultural Competence in the caring professions*. Jessica Kingsley, London.

OFFICE OF NATIONAL STATISTICS (2003). Ethnic group statistics: A guide for the collection and classification of ethnicity data". Office for National Statistics. [http://www.statistics.gov.uk/about/ethnic\\_group\\_statistics/downloads/ethnic\\_group\\_statistics.pdf](http://www.statistics.gov.uk/about/ethnic_group_statistics/downloads/ethnic_group_statistics.pdf)

OFFREDY, M. (2002) Access to primary care: decision making by GP receptionists. *Br J Community Nurs*, 7, 480-5.

OWENS, A. & RANDHAWA, G. (2004) 'It's different from my culture; they're very different': providing community-based, 'culturally competent' palliative care for South Asian people in the UK. *Health & Social Care in the Community*, 12, 414-421.

PAPADOPOULOS, I (2006). Culturally competent research. A model for its development. In Nazroo, J. Health and Social Research in Multiethnic Societies (Chapter 6). Routledge, Abingdon.

PARLIAMENTARY OFFICE & POST NOTE (2007) Ethnicity and health. 1-4.

PARMENTIER, H., GOLDING, S., ASHWORTH, M. & ROWLANDS, G. (2004) Community pharmacy treatment of minor ailments in refugees. *Journal of Clinical Pharmacy & Therapeutics*, 29, 465-469.

PARTOP, I., MORLEY, A., and PANTON, RS (1986). A survey of patients from ethnic minorities: Do they use community pharmacy services effectively? *Pharmaceutical Journal*, 724-725 (Nov).

PARTRIDGE, M. & HUSSEIN, S. (2002) Perceptions of asthma in South Asians and their views on educational materials and self-management plans: a qualitative study. *Patient Education and Counseling* 48, 189-194.

PATEL, C. & BHOPAL, R. (2004). The epidemic of coronary heart disease in South Asian populations: causes and consequences. Birmingham, South Asian Health Foundation.

PATEL, C. & SHAH, A. (2005) Prevention, Treatment and Rehabilitation of cardiovascular disease in South Asians. The Stationery Office, London, South Asian Health Foundation and Department of Health.

PATEL, S., PEACOCK, S. M., MCKINLEY, R. K., CARTER, D. C. & WATSON, P. J. (2008) GPs' experience of managing chronic pain in a South Asian community - a qualitative study of the consultation process. *Family Practice*, 25, 71-77.

PATTON, M. (1990). Qualitative evaluation and research methods. London, Sage.

PETERS, J. & JACKSON, M. (2005) Accessibility and use of touchscreens by black and ethnic minority groups in the three cities project. *Ethn Health*, 10, 199-211.

PIERONI, A., HOULIHAN, L., ANSARI, N., HUSSAIN, B. & ASLAM, S. (2007) Medicinal perceptions of vegetables traditionally consumed by South-Asian migrants living in Bradford, Northern England. *J Ethnopharmacol*, 113, 100-10.

PIERONI, A., SHEIKH, Q. Z., ALI, W. & TORRY, B. (2008) Traditional medicines used by Pakistani migrants from Mirpur living in Bradford, Northern England. *Complement Ther Med*, 16, 81-6.

PLATT, L (2002) Parallel lives? Poverty among ethnic minority groups in Britain, CPAG London

PLATTS, A. E., TANN, J. & CHISHTI, Z. (1997) Ethnic minority pharmacy practice. *International Journal of Pharmacy Practice*, 5, 72-80.

POPE, C., ZIEBLAND, S. & MAYS, N. (2000) Qualitative research in health care. Analysing qualitative data. *BMJ*, 320, 114-6.

POPE, C and MAYS, N. (1999). Qualitative Research in Health Care (Second edition). BMJ Publishing /Blackwell publications. Oxford.

POPE, C and MAYS, N. (2006). Qualitative Research in Health Care (Third edition). BMJ Publishing /Blackwell publications. Oxford.

PORTEOUS, T. & BOND, C. (2003) Novel provision of pharmacy services to a deprived area: a pharmaceutical needs assessment. *International Journal of Pharmacy Practice*, 11, 47-54.

PORTEOUS, T., RYAN, M., BOND, C & HANNAFORD, P. (2006). Preferences for self-care or professional advice for minor illness: a discrete choice experiment. *Br J Gen Pract*, 56, 911-7.

PRESLEY, F. & SHAW, A. (1995) Race and health: An information sources guide, Kings Fund Centre.

PRIMARY CARE CONTRACTING (PCC) (2007). PBC Bulletin 7: Building PBC capacity through community pharmacy.

[http://www.pcc.nhs.uk/uploads/Pharmacy/sept\\_07/pbc\\_bulletin\\_building\\_pbc\\_capacity\\_throu gh\\_pharmacy.pdf](http://www.pcc.nhs.uk/uploads/Pharmacy/sept_07/pbc_bulletin_building_pbc_capacity_throu gh_pharmacy.pdf) (accessed December 2008).

PRINGLE, M. & ROTHERA, I. (1996) Practicality of recording patient ethnicity in general practice: descriptive intervention study and attitude survey. *BMJ*, 312, 1080-2.

PROPRIETARY ASSOCIATION OF GREAT BRITAIN (PAGB) (2009). Making the case for the self care of minor ailments. London.

<http://www.pagb.co.uk/information/PDFs/Minoraillmentsresearch09.pdf> accessed Jun 2010).

PUMTONG, S., BOARDMAN, H. & ANDERSON, C. (2008). Pharmacists' perspectives on the Pharmacy First Minor Ailments Scheme. *International Journal of Pharmacy Practice*, 16, 73-80.

PURI, H., BISSELL, P. & ANDERSON, C. (2003) Explanations for inequalities in health among people of South Asian origin living in the UK: the views of pharmacists. *International Journal of Pharmacy Practice*, 11, R5.

QURESHI, B. (2002) Diabetes in Ramadan: Fasting during Ramadan affects drug treatment. *J R Soc Med*, 95, 489-90.

RANDHAWA, G. & OWENS, A. (2004). The meanings of cancer and perceptions of cancer services among South Asians in Luton, UK. *British Journal of Cancer*, 91, 62-68.

RANDHAWA, G. (2007) *Tackling Health Inequalities for Minority Ethnic Groups: Challenges and opportunities*, Better Health Briefing 6, London: Race Equality Foundation.

RASHED, A. (1992). The fast of Ramadan. *BMJ* 304, 521.

RASHID, A. & JAGGER, C. (1992) Attitudes to and perceived use of health care services among Asian and non-Asian patients in Leicester. *Br J Gen Pract*, 42, 197-201.

RASHID, A., JAGGER, C. & GOODYER, L. (1996) Views of Asians and non-Asians on sources of drug information and the desirability for medication to be made available over the counter. *Br J Gen Pract*, 46, 609-10.

RASHID, A. (2009). Evidence based practice in Pakistan. PhD thesis (unpublished). University of Birmingham.

RHODES, P., SMALL, N., ISMAIL, H., & WRIGHT, J. (2008). The use of biomedicine, complementary and alternative medicine, and ethnomedicine for the treatment of epilepsy among people of South Asian origin in the UK. *BMC Complementary and Alternative Medicine* 2008, 8:7

RICHARDSON, E & POLLOCK, A. (2010). Community pharmacy: moving from dispensing to diagnosis and treatment. *BMJ*; 340:c2298

RITCHIE, J. & LEWIS, J. (2004) *Qualitative Research Practice: A guide for Social Science*, London, Sage Publications.

RITCHIE, J. & SPENCER, L. (2002) *Qualitative Data Analysis for Applied Policy research*. IN HUBERMAN, A. & MILES, M. (Eds.) *The Qualitative Researcher's companion*. Thousand Oaks, CA: Sage Publications.

ROGERS, A., HASSELL, K., NOYCE, P. & HARRIS, J. (1998) Advice-giving in community pharmacy: variations between pharmacies in different locations. *Health Place*, 4, 365-73.

ROYAL COLLEGE OF PHYSICIANS (2005) *Doctors in society: medical professionalism in a changing world*. Report of a Working Party of the Royal College of Physicians of London.

ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (RPSGB) (1996). *New Horizons: Pharmacy in a New Age*, summary of responses. RPSGB, London

ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (RPSGB) (1997). *Building the future*. RPSGB, London

ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (RPSGB) (1999). The public's use of community pharmacies as a primary health care resource. The School of Pharmacy and Pharmaceutical Sciences, The National Primary Care Research and Development Centre (NPCRDC), University of Manchester.

ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (RPSGB) (2005). The Code of Ethics for pharmacists. London: The Royal Pharmaceutical Society.

ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (RPSGB) (2006) Healthcare professional education & training: How does Pharmacy in Great Britain compare? London: The Royal Pharmaceutical Society.

ROYAL PHARMACEUTICAL SOCIETY (RPSGB) (2007a). Practice Based Commissioning: A resource for community pharmacists in England.

<http://www.rpsgb.org.uk/pdfs/pbcguid.pdf> (accessed Dec 2007).

ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (RPSGB) (2007b). The code of ethics for pharmacists and pharmacy technicians. <http://www.rpsgb.org/pdfs/coept.pdf> (accessed Dec 2009)

RUDAT, K. (1994) Black and Minority Ethnic Groups in England: Health and Lifestyles. London, England: Health Education Authority.

RYAN, K., BISSELL, P. & MORECROFT, C. (2007) Narratives about illness and medication: a neglected theme/new methodology within pharmacy practice research. Part II: medication narratives in practice. *Pharm World Sci*, 29, 353-60.

SAKS, M. & ALLSOP, J. (2007) Researching Health: Qualitative, quantitative and Mixed Methods, Sage.

SAVAGE, I. (1996) Time for prescription and OTC advice in independent community practice. *Pharmaceutical Journal*, 258, 873-877.

SCHAAFSMA, E., RAYNOR, T. D. & DE JONG-VAN DEN BERG, L. (2003). Accessing medication information by ethnic minorities: barriers and possible solutions. *Pharmacy World & Science: PWS*, 25, 185-190.

SCHAFHEUTLE, E., HASSELL, K., NOYCE, P. & WEISS, M. (2002). Access to medicines: cost as an influence on the views and behaviour of patients. *Health Soc Care Community*, 10, 187-95.

SCHREIBER, R and STERN, P (2001). Using grounded theory in nursing. Springer Publishing Company, New York.

SEAMARK, C. (2003) Barriers between community pharmacists and GPs. *Br J Gen Pract*, 53, 885; author reply 885-6.

SHAH, R. & OGDEN, J. (2006) 'What's in a face? The role of doctor ethnicity, age and gender in the formation of patients' judgements: an experimental study. *Patient Education and Counseling*, 60, 136-141.

SHAHZAD, A. (2003) Diabetes in Ramadan. *J R Soc Med*, 96, 52.

SHELDON, T.A. AND PARKER, H. (1992) Race and ethnicity in health research. *Journal of Public Health Medicine*, 14(2), 104-10.

- SHETTY, K. V. & JOHNSON, N. W. (1999) Knowledge, attitudes and beliefs of adult South Asians living in London regarding risk factors and signs for oral cancer. *Community Dent Health*, 16, 227-31.
- SHILLING, C. (1993). *The Body and Social Theory*. Thousand Oaks, CA: Sage.
- SINHA, S., CURTIS, K., JAYAKODY, A., VINER, R. & ROBERTS, H. (2007) 'People make assumptions about our communities': sexual health amongst teenagers from black and minority ethnic backgrounds in East London. *Ethn Health*, 12, 423-41.
- SMAJE, C. (1995) *Health, Race and Ethnicity: Making Sense of the Evidence*. London, Kings Fund.
- SMAJE, C. (1996). The ethnic patterning of health: new directions for theory and research. *Sociology of Health and Illness*, 18, 139-71.
- SMAJE C. (1997). Not just a social construct: Theorising race and ethnicity. *Sociology* 31: 307-27.
- SMITH, F. (2002) *Research Methods in Pharmacy Practice*, London, Pharmaceutical Press.
- SMITH, J (2005). The Shipman enquiry. <http://www.the-shipman-inquiry.org.uk/reports.asp> (accessed Dec 2008).
- SNAPE, D. and SPENCER, L. (2003), 'The foundations of qualitative research', in Ritchie, J. and Lewis, J. (Eds), *Qualitative Research Practice*, Sage, London
- SPENCER, J. A. & EDWARDS, C. (1992) Pharmacy beyond the dispensary: general practitioners' views. *BMJ (Clinical Research Ed.)*, 304, 1670-1672.
- STEVENSON, F., COX, K., BRITTEN, N. & DUNDAR, Y. (2004). A systematic review of the research on communication between patients and health care professionals about medicines: the consequences for concordance. *Health Expectations* 7, 235-245.
- SPROSTON, K. & MINDELL, J. (2006) *Health survey for England 2004: The Health of Minority Ethnic groups. Summary of the key findings*. London, The Information centre. National centre for Social research and University College Medical School, London.
- STONE, M. A., PATEL, H., PANJA, K. K., BARNETT, D. B. & MAYBERRY, J. F. (1998) Reasons for non-compliance with screening for infection with *Helicobacter pylori*, in a multi-ethnic community in Leicester, UK. *Public Health*, 112, 153-6.
- STRAUSS, A. & CORBIN, J. (1990) *Basics of qualitative research*. . Thousand Oaks, California, Sage publications.
- STRAUSS, A. & CORBIN, J. (1998) *Basics of qualitative research: grounded theory procedures and techniques*. London. Sage Publications.
- SZCZEPURA, A., CLARK M.D, JOHNSON, M.R.D. & OWEN D (1999) Assessment of the costs to the NHS arising from the need for interpreter, advocacy and translation services. Coventry, Centre for Health Services Studies, University of Warwick.



SZCZEPURA, A., JOHNSON, M.R.D., GUMBER, G., JONES, K., & CLAY, D (2004). A review of the research evidence on ethnicity and communication. Coventry, UK, Centre for Health Services Studies.

SZCZEPURA, A. (2005) Access to health care for ethnic minority populations. *Postgrad Med J*, 81, 141-147.

SZCZEPURA, A., JOHNSON, M.R.D, GUMBER, A., JONES, K., CLAY, D. & SHAW, A. (2005). An overview of the research evidence on ethnicity and communication in healthcare. *Report to the Department of Health* Coventry, Warwick Medical School (CEEHD).

TARRANT, C., STOKES, T. & BAKER, R. (2003) Factors associated with patients' trust in their general practitioner: a cross-sectional survey. *Br J Gen Pract*, 53, 798-800.

THOMAS, V & COHN, T. (2006). Communication skills and cultural awareness courses for healthcare professionals who care for patients with sickle cell disease. *Journal of Advanced Nursing*, 53 (4): 480-488

TUFFNELL, D., NUTTALL, K., RAISTRICK, J. & JACKSON, T. (1994). Use of translated written material to communicate with non-English speaking patients. *BMJ*, 309, 992.

TULLY, M., HASSELL, K. & NOYCE, P. (1997). Advice-giving in community pharmacies in the UK. *J Health Serv Res Policy*, 2, 38-50.

TURNER, P (1986). The Nuffield report: -a signpost for pharmacy. *British Medical Journal*, 292: 1031-1033

TURNER, D., TARRANT, C., WINDRIDGE, K., BRYAN, S., BOULTON, M., FREEMAN, G., & BAKER, R. (2007) Do patients value continuity of care in general practice? An investigation using stated preference discrete choice experiments. *Journal of Health Services Research & Policy*, 12, 132-137.

UK CRC SCREENING PILOT EVALUATION (ETHNICITY) TEAM (2003). Ethnicity: UK Colorectal Cancer Screening Pilot. Final Report  
<http://www.cancerscreening.nhs.uk/bowel/ethnicity-finalreport.pdf> (accessed Dec 2007).

VALLIS, J., WYKE, S. & CUNNINGHAM-BURLEY, S. (1997) Users' views and expectations of community pharmacists in a Scottish commuter town. *Pharmaceutical Journal*, 258, 457-460.

WALKER, I., ASLAM, M. & DAVIS, S. (1980). Use of a Bradford pharmacy by the Asian and indigenous populations. *Pharmaceutical Journal*, 225, 703-705.

WALKER, R (2000). Pharmaceutical public health: the end of pharmaceutical care? *Pharmaceutical Journal*, 264:340-1

WANLESS, D. (2002). The Wanless Report. Securing our Future Health: Taking a Long-Term View. HM Treasury report. London

WANLESS, D. (2004). Securing good health for the whole population: Final report - February 2004. HM Treasury report. London

WANLESS D, APPLEBY J, HARRISON A, PATEL D. (2007). Our future health secured? London: King's Fund  
[http://www.kingsfund.org.uk/publications/kings\\_fund\\_publications/our\\_future.html](http://www.kingsfund.org.uk/publications/kings_fund_publications/our_future.html) (accessed Dec 2009)

WARD, P. R., BISSELL, P. & NOYCE, P. R. (1998) Medicines counter assistants: roles and responsibilities in the sale of deregulated medicines. *International Journal of Pharmacy Practice*, 6, 207-215.

WARD, P., BISSELL, P. & NOYCE, P. (2000). Criteria for assessing the appropriateness of patient counselling in community pharmacies. *Ann Pharmacother*, 34, 170-5.

WEBSTER, R. (1997) The experiences and health care needs of Asian coronary patients and their partners. Methodological issues and preliminary findings. *Nurs Crit Care*, 2, 215-23.

WEBSTER, R., THOMPSON, D. & MAYOU, R. (2002). The experiences and needs of Gujarati Hindu patients and partners in the first month after a myocardial infarction. *European Journal of Cardiovascular Nursing*, 1, 69-76.

WEST, M.A. (1999). Communication and teamworking in healthcare. *NT Research*, 4(1), 8-16.

WHITEHEAD, M (1991). The concepts and principles of equity and health. Copenhagen: WHO/EURO

WHITTINGTON, Z., CANTRILL, J., HASSELL, K., BATES, F. & NOYCE, P. (2001a) Community Pharmacy management of minor conditions - the "Care at the Chemist" scheme. *The Pharmaceutical Journal* 266, 425-428.

WHITTINGTON, Z., HASSELL, K., CANTRILL, J. & AL, E. (2001b) Care at the Chemist: a question of access. A feasibility study comparing community pharmacist and general practice management of minor ailments. . University of Manchester, School of Pharmacy and Pharmaceutical Sciences.

WIGGINS, H. (1990) Meeting the needs of minority ethnic groups. *British Journal of Pharmaceutical Practice*, 12, 170, 172-173, 176-177.

WILD, S. AND MCKEIGUE, P. (1997) Cross sectional analysis of mortality by country of birth in England and Wales. *British Medical Journal*, **314**, 705–10.

WILLIAMSON, V., WINN, S., LIVINGSTONE, C. & PUGH, A. (1992). Public views on an extended role for community pharmacy. *International Journal of Pharmacy Practice*, 1, 223-229.

WILLIAMSON, E; DRIVER, S; BAXTER, K (2009). Stockley's Herbal Medicines Interactions (1<sup>st</sup> edition). The Pharmaceutical Press, London.

WINDRIDGE, K., TARRANT, C., FREEMAN, G.K., BAKER, R., BOULTON, M., LOW, J. (2004) Problems with a 'target' approach to access in primary care: a qualitative study. *British Journal of General Practice*, 54, 364-6.

WINGFIELD, J. (2006) Professionalism for pharmacists. *The Pharmaceutical Journal*, 276, 169-170.



WINGFIELD, J., BISSELL, P. & ANDERSON, C. (2004) The Scope of pharmacy ethics-an evaluation of the international research literature, 1990-2002. *Social Science & Medicine*, 58, 2383-96.

WOOD, A. & ZHOU, H. (1991). Ethnic differences in drug disposition and responsiveness. *Clinical Pharmacokinetics*, 20, 350-373.

WRIGHT, J, PICKARD, N, WHITFIELD, A, HAKIN, N. (2000). A population-based study of the prevalence, clinical characteristics and effect of ethnicity in epilepsy. *Seizure*, 9 (5), 309-313 (July)

ZERMANSKY, A. G., PETTY, D. R., RAYNOR, D. K., FREEMANTLE, N., VAIL, A. & LOWE, C. J. (2001) Randomised controlled trial of clinical medication review by a pharmacist of elderly patients receiving repeat prescriptions in general practice. *BMJ*, 323, 1340-3.